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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds on
Tuesday, 26th January, 2010 at 10.00 am

(A pre-meeting will be held for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

S Bentley	-	Weetwood;
J Chapman	-	Weetwood;
D Congreve	-	Beeston and Holbeck;
M Dobson (Chair)	-	Garforth and Swillington;
D Hollingsworth	-	Burmantofts and Richmond Hill;
J Illingworth	-	Kirkstall;
M Iqbal	-	City and Hunslet;
G Kirkland	-	Otley and Yeadon;
A Lamb	-	Wetherby;
P Wadsworth	-	Roundhay;
L Yeadon	-	Kirkstall;

Co-opted Members

Vacancy	-	Leeds Voice
Vacancy	-	Leeds LINk

Please note: Certain or all items on this agenda may be recorded on tape

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:- **No exempt items or information have been identified on this agenda.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal/prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence.	
6			**MINUTES OF THE PREVIOUS MEETING** To receive and approve the minutes of the previous meeting held on 15th December 2009.	1 - 8
7			**SCRUTINY INQUIRY: THE ROLE OF THE COUNCIL AND ITS PARTNERS IN PROMOTING GOOD PUBLIC HEALTH (SESSION 2 - CONTINUED)** To consider the attached report of the Head of Scrutiny and Member Development introducing the continuation of the second session of the Scrutiny Board's inquiry aimed at considering the role of the Council and its partners in promoting good public health.	9 - 248
8			**HEALTH PROPOSALS WORKING GROUP - UPDATE** To consider the attached report of the Head of Scrutiny and Member Development presenting a summary of the issues discussed at the first meeting of the working group on 3rd December 2009 and seeking endorsement from the Board on any proposed actions and/or recommendations.	249 - 260

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**LEEDS TEACHING HOSPITALS NHS TRUST - FOUNDATION TRUST CONSULTATION: SCRUTINY BOARD SUBMISSION** To consider the attached report of the Head of Scrutiny and Member Development presenting the Scrutiny Board's submission issued to LTHT in response to the consultation around the Trust's initial proposals to become an NHS Foundation Trust for the Board to formally endorse.	261 - 268
10			**UPDATED WORK PROGRAMME 2009/10** To consider the attached report of the Head of Scrutiny and Member Development presenting an update on current activity and the Board's revised outline work programme for the remainder of the current municipal year, for the Board to consider, amend and agree as appropriate.	269 - 352
11			**DATE AND TIME OF NEXT MEETING** To note that the next meeting of the Board will be held on 16th February 2010.	

SCRUTINY BOARD (HEALTH)

TUESDAY, 15TH DECEMBER, 2009

PRESENT: Councillor M Dobson in the Chair

Councillors S Bentley, J Chapman, D Congreve, D Hollingsworth, J Illingworth, G Kirkland, A Lamb and L Yeadon

CO-OPTEE: E Mack

50 Late Items

In accordance with his powers under Section 100B(4)(b) of the Local Government Act 1972, the Chair admitted to the agenda the draft statement from the Board to the Secretary of State relating to Agenda Item 8 'Renal Services; Statement' (Minute No. 55 refers). The draft statement had been unavailable at the time of the agenda despatch and needed to be considered by the Board before their next meeting in January 2010.

The Chair also admitted to the agenda additional information which was relevant to Agenda Item 7 'Scrutiny Inquiry: The Role of the Council and its Partners in Promoting Good Public Health (Session 2)' (Minute No. 54 refers).

The late and additional material had been circulated to Members prior to the meeting.

51 Declarations of Interest

In respect of Agenda Item 8 'Renal Services: Statement' (Minute No. 55 refers), Councillor Chapman declared a personal interest as a member of her family was about to start work in one of the children's renal units.

In respect of Agenda Item 7 'Scrutiny Inquiry: The Role of the Council and its Partners in Promoting Good Public Health (Session 2)' (Minute No. 54 refers), Councillor Yeadon indicated that, as she was a member of the Plans Panel (West) and could possibly be considering certain issues within the debate at a later date in that capacity, in order to avoid any perception of pre-determination when the matter came before the Plans Panel, she stated that she would not be taking part in the discussions on this particular issue at this meeting.

Later in the meeting during the consideration of Agenda Item 7 'Scrutiny Inquiry: The Role of the Council and its Partners in Promoting Good Public Health (Session 2)' (Minute No. 54 refers), Councillor Illingworth also declared a personal interest in this item as an employee of the University of Leeds.

52 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Iqbal and Wadsworth.

53 Minutes of the Previous Meeting

RESOLVED – That the minutes of the meeting held on 24th November 2009 be confirmed as a correct record.

54 Scrutiny Inquiry: The role of the Council and its partners in promoting good public health (Session 2)

The Head of Scrutiny and Member Development submitted a report providing Members with information on the second session of the Board's inquiry into the role of the Council and its partners in promoting good public health.

The second session of the inquiry was to consider issues associated with reversing the rise in levels of obesity and promoting an increase in the levels of physical activity. Attached to the report in this regard was the following information:

- Local Development Framework - (Appendix 4)
- Vision for Council Leisure Centres - (Appendix 5)
- Leeds Physical Activity Strategy - (Appendix 6)
- Parks and Green Space Strategy - (Appendix 7)
- Can't Wait – Leeds Childhood Obesity Strategy - (Appendix 8)
- Adult Obesity - (Appendix 9)

Also accepted at the meeting as additional information from Education Leeds was:

- Information on the Health Initiatives and Wellbeing Team, and
- Information on the School Meals Strategy

Attached at Appendix 3 to the report was a request for scrutiny received in early October 2009 on behalf of local residents of Hyde Park and surrounding areas, seeking the involvement of the Scrutiny Board (Health) to examine the health aspects of playing field provision in the inner-city areas of Leeds. As it was considered that this request was within the terms of reference of this inquiry, it was felt appropriate to invite representatives of the local residents to address the Board in this regard.

Other documents that were attached to the report as background information for this second session of the inquiry were:

- Action Plan for the Improvement Priorities in the Health and Wellbeing Partnership Plan (2009-2012) of the Leeds Strategic Plan (2008-2011) – (Appendix 1)
- NICE guidance CG43 (Quick reference guide 1: For local authorities, schools and early years providers, workplaces and the public) – (Appendix 2)

The Chair welcomed first to the meeting Sue Buckle, a local resident from the Hyde Park area of Leeds, who had submitted a request for the Board to look at the health aspects of playing field provision in the inner city areas of Leeds, with special reference to the Leeds Girls High School's planning application to develop their site in Hyde Park. Ms Buckle had also previously presented a deputation to Council in September 2008 regarding the lack of sports pitches for use by local schools and the community in the Hyde Park area.

Ms Buckle advised the Board that she was attending the meeting on behalf of parents and residents in Hyde Park and outlined the reasons for the scrutiny request, which she summarised as:

- Hyde Park was the second most densely populated area in Leeds.
- Primary schools in the area were woefully short of play space.
- There was no easily accessible swimming pool.
- The open space that was available was, in many cases, unsuitable due to dog walkers and rubbish and glass left by people taking part in picnics and barbecues.
- Student accommodation had been built on areas of open space that had been available.

Ms Buckle also stated that she believed that:

- Schools were crucial in instilling the skills and enjoyment of sport at a young age.
- When parents saw how much their children were enjoying themselves, they would be more likely to make sure that their children got involved and joined in themselves.
- Money, time and accessibility were also all very important limiting factors to exercise.
- There were competing pressures for children's time, particularly to sit indoors at the computer rather than playing out.

Ms Buckle concluded that what the Hyde Park area of Leeds needed was more sports facilities and play space and the former Leeds Girls High School's site presented an opportunity for this.

Discussion followed on the local issues raised by Ms Buckley and also on the broader concerns of providing sport and play facilities to the wider population of Leeds. These discussions included in brief summary:

- Issues surrounding the former Leeds Boys Grammar School, which had been bought by the University of Leeds and where the sports facilities had not been preserved for the use of the local community.
- The need to encourage local people to use the university sports facilities.
- The 'cinder moor' at Woodhouse – its past and present use.
- The previously proposed closure of South Leeds Sports Centre and its importance to the health and wellbeing of the people in and around the areas of Beeston Hill and Holbeck.
- That the inquiry should bear in mind other inner city areas which experienced similar levels of deprivation and provision to the Hyde Park area.

- The general loss of play space to housing.
- The inadequate transport infrastructure which caused sports facilities to be inaccessible to many.
- That there were a number of limiting factors that had an impact on people's ability to participate in physical activities and undertake exercise, including time, resources, access and culture.
- Agreement that schools were crucial in instilling a healthy lifestyle at an early stage.
- That having no school playing fields was not a recent phenomenon.

The Chair thanked Ms Buckley for her attendance and then welcomed the following Council officers to the meeting to respond to queries and comments from the Board:

- Steve Speak, Deputy Chief Planning Officer (Leeds City Council, City Development),
- David Feeney, Head of Planning and Economic Policy (Leeds City Council, City Development),
- Mark Allman, Head of Sport and Active Recreation (Leeds City Council, City Development), and
- John Freeman, Head of Service (Health Initiatives and Wellbeing Team), Education Leeds.

The Head of Service (Health Initiatives and Wellbeing Team), Education Leeds, clarified for the Board the arrangements for swimming tuition in schools: that all pupils in Years 4/5 received swimming lessons and additional lessons were given where children failed to reach the current nationally agreed 25 metre standard. He also advised that school swimming lessons, in common with other aspects of the physical education (PE) curriculum, were seen as a skills development rather than as a form of cardio vascular exercise. Development of skills could subsequently help children access a range of activities (through local clubs) outside the school environment.

Officers also advised that non-competitive activities such as dance and performance art also had a role to play in counteracting obesity.

Members then discussed the issues and raised, in brief summary, the following concerns with regard to physical activity within the school curriculum:

- The number of children who did not achieve the 25 metre swimming standard.
  (The Head of Service (Health Initiatives and Wellbeing Team), Education Leeds, agreed to supply these figures to the Board.)
- The increased range of activities being made available to young people, with the result that the curriculum was more about learning skills than just taking part in rigorous physical activity.
- Opportunities for using the new skills within the curriculum and outside the school day.
- Quality of teaching.

Members were advised that extensive in-service training had taken place to improve the skills of primary PE teachers.

Members also questioned officers on the imbalance of the availability of sport and play provision throughout the city and expressed their concerns that the gap between the poorer and wealthier areas of the city, with regard to health outcomes, was widening. Officers advised in brief summary:

- That improving the infrastructure of sports facilities in certain areas of the city was a long-term aspiration, in the meantime the Authority had to be creative and address transport and accessibility issues by for instance looking at partnership working with Metro.
- That best practice in other authorities was sought, however Leeds was the best performing city in Yorkshire and among the Core Cities in terms of adult participation.
- That with regard to the Core Strategy document and Policy N6, the Core Strategy was not intended to go into detail, this would be covered in other documents. There would also be ample opportunity for discussion on the Core Strategy as it was not expected to be published until autumn 2010.
- That with regard to PPG17 in the Core Strategy, a needs assessment had been carried out and the second part of the work would be completed early in the new year.
- That School Sports Partnership Managers and Co-ordinators from Education Leeds were working with other services and voluntary community clubs to increase take up in physical activities outside of and beyond school.
- That initiatives funded by the Government such as Sports Unlimited were helping to broaden the range of sports available.
  (The Head of Service (Health Initiatives and Wellbeing Team), Education Leeds, agreed to provide the Board with information on this initiative.)
- That the Healthy Challenge initiative had been in place for the past 3 years and the Be Healthy Family Challenge would start in 2010.
- That there would be a month devoted to sport within the Year of the Volunteer.
- That the use of school facilities by local communities in the evenings and weekends was inconsistent across the city.
  (The Head of Service (Health Initiatives and Wellbeing Team), Education Leeds, agreed to provide the Board with information on the barriers to using schools out of hours.)
- Work was underway to help identify particular successes and areas of best practice around a number of initiatives aimed at increasing physical activity and participation levels, that had been rolled out across the City.

Members also discussed the role that planning legislation could have in the provision of playing fields and sports facilities and requested that Members, who were best placed to advise on local issues, be consulted at an earlier stage in the planning decision making process.

There was also discussion around the role of planning officers in negotiations often associated with major planning applications. Officer stressed that the

aim of such negotiations was to secure 'the best available deal' for local communities. The importance and role of the locally agreed N6 policy (ie the identification and designation of open space provision) across the City was also discussed. Members of the Board stressed their desire to see such policies strictly and rigorously enforced and considered at an early stage in the process for proposed major developments. There was also some discussion around the Council's ability to purchase land to help preserve open space and the value of such purchases.

Members also discussed the importance of the parents becoming involved and the need to improve whole family attitudes to taking part in sports and concluded that this could only be resolved with partnership working and a whole Council approach.

The Chair summarised that the main issues to come out of this second session of the inquiry into the role of the Council and its partners in promoting good public health were the need to:

- address inequality of sport and play provision across the city,
- improve access to facilities,
- focus limited resources on the needs of inner city children and adults,
- identify and examine best practice, and
- further develop partnership working and to adopt a whole Council approach.

The Chair thanked LCC officers for attending and apologised to the representatives from NHS Leeds for the meeting overrunning and not being able to hear their contributions. It was agreed that these officers would return to the Board's January meeting to continue this discussion. It was also agreed that officers would be requested to provide information around progress of the 'narrowing the gap' agenda.

RESOLVED –

(a) That the contents of the report and appendices be noted.

(b) That the main issues to come out of this second session of the inquiry, and summarised by the Chair above, be included in the Board's final scrutiny inquiry report.

(c) That the following information be supplied to the Board by the Head of Service (Health Initiatives and Wellbeing Team), Education Leeds:
   - The number of children who did not achieve the 25 metre swimming standard,
   - Information on the local sports alliances,
   - Information on Sports Unlimited,
   - Information on the barriers to using schools out of hours.

(d) That the representatives from NHS Leeds be invited to return to the January 2010 meeting of the Board and that information around 'narrowing the gap' also be presented to that meeting.

(Note: Councillor Chapman left the meeting at 11.55am during the consideration of this item.)

55 Renal Services: Statement

The Head of Scrutiny and Member Development submitted a report presenting the Scrutiny Board (Health) with a summary of the background to the issues regarding the provision of renal services (dialysis) across the Trust, particularly in terms of provision at Leeds General Infirmary (LGI). The statement, which it had been agreed to send to the Secretary of State for Health at the previous meeting of the Board on 24th November 2009, had been accepted earlier in the meeting in its draft form as a Late Report.

The Chair stated that the draft of the statement to the Secretary of State for Health had previously been circulated to Members and apart from the inclusion of a timeline in Recommendation 1 and other minor amendments, it was agreed that the statement could be released.

RESOLVED –
(a) That the contents of the report be noted.
(b) That the draft statement to the Secretary of State for Health be amended as outlined above and released.

56 Health Proposals Working Group - Update

The Head of Scrutiny and Member Development had submitted a report to present the minutes of the first meeting of the Health Proposals Working Group held on 3rd December 2009.

However, due to the fact that the minutes of this first meeting of the Health Proposals Working Group were not yet available, it was agreed to defer discussion on the proposed actions and recommendations to the January 2010 meeting of the Board.

RESOLVED – That this item be deferred to the January 2010 meeting of the Board.

57 Updated Work Programme 2009/10

The Head of Scrutiny and Member Development submitted a report presenting an outline work programme for the Board to consider, amend and agree as appropriate.

Attached to the report was the following information:
- Scrutiny Board (Health) Work Programme 2009/10 – updated December 2009 - (Appendix 1)
- Minutes of the Executive Board meeting held on 24th November 2009 - (Appendix 2)

Steven Courtney, Principal Scrutiny Adviser, advised that the Work Programme would be updated to include in the 26th January 2010 meeting of the Board the concluding part of the second session of the Scrutiny Inquiry into public health and the update on the Health Proposals Working Group.

The following additions to the Work Programme were also requested by Members:

- Why the Narrowing the Gap initiative was not working in terms of improving healthy outcomes.
- In the light of NHS Leeds' decisions to withdraw from projects in Kirkstall and Holt Park, what was the PCT's long term strategy.

As the consultation deadline on the LTHT's application for Foundation Trust status was prior to the next meeting of the Board, it was agreed to circulate to Members a summary of the Board's conclusions via email.

RESOLVED –

(a) That the report and appendices be noted.

(b) That, subject to the above comments and additions, the Work Programme be updated as agreed.

(c) That a summary of the Board's conclusions on the LTHT's application for Foundation Trust status be circulated via email for Members' approval.

58 Date and Time of Next Meeting

Noted that the next meeting of the Board would be held on Tuesday 26th January 2010 at 10.00am with a pre-meeting for Board Members at 9.30am. **PLEASE NOTE THE CHANGE OF DATE.**

The Chair brought the meeting to a close by thanking Co-opted Member, Mr Eddie Mack, who was retiring from the Board, for his valuable contribution to the Board's discussions over the years and wishing him well for the future.

The meeting concluded at 12.20pm.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 January 2010

Subject: Scrutiny Inquiry: The role of the Council and its partners in promoting good public health (Session 2 – continued)

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to introduce the continuation of the second session of the Scrutiny Board's inquiry aimed at considering the role of the Council and its partners in promoting good public health.

2.0 Background

2.1 At its meeting on 22 September 2009, the Scrutiny Board (Health) agreed terms of reference for the above inquiry. In this regard, the Board agreed to consider arrangements relating to four specific areas of public health, namely:

- Improving sexual health and reducing the level of teenage pregnancies;
- Reversing the rise in levels of obesity and promoting an increase in the levels of physical activity;
- Promoting responsible alcohol consumption; and,
- Reducing the level of smoking;

2.2 In considering the promotion of good public health, the overall purpose of the inquiry is to make an assessment of the role of the Council and its partners in developing, supporting and delivering targets associated with improving specific aspects of public health.

Health and Wellbeing

2.3 As previously reported, Health and wellbeing is one of eight key themes within the Leeds Strategic Plan (2008-2011), with reversing the rise in levels of obesity and

promoting an increase in the levels of physical activity being a specific improvement priority.

2.4 Based on the outcomes and priorities agreed by the Council and its partners and shaped by local people, the Health and Wellbeing Partnership Plan (2009 – 2012) is part of the broader Leeds Strategic Plan: It concentrates on the main high level actions necessary to help deliver the agreed strategic outcomes and priorities. These high level actions are detailed in the attached action plan for the improvement priorities (Appendix 1). Actions associated with reversing the rise in levels of obesity and promoting an increase in the levels of physical activity are detailed in action plan number 4 in Appendix 1.

2.5 At its previous meeting (15 December 2009), the Scrutiny Board heard from a member of the public concerned with the health implications associated with playing field provision in the inner city areas of Leeds: In addition, the Scrutiny Board also took evidence from a range of Council officers, including the:

- Deputy Chief Planning Officer
- Head of Planning and Economic Policy
- Head of Sport and Active Recreation
- Head of Service (Health Initiatives and Wellbeing Team), Education Leeds

2.6 However, due to the length of debate at the previous meeting, the Board was unable to discuss the contribution of NHS Leeds associated with particular aspect of public health: The Scrutiny Board subsequently agreed to defer this aspect of the session to its January 2010 meeting.

<u>The National Institute for Health and Clinical Excellence (NICE)</u>

2.7 Also at its meeting on 15 December 2009, the Scrutiny Board was advised of the work of NICE – as the independent organisation responsible for providing national guidance on promoting good health and the prevention and treatment of ill health.

2.8 As part of this, the Scrutiny Board was presented with a guidance document that covered the prevention, identification, assessment and management of overweight and obesity in adults and children – . NICE guidance CG43 (Quick reference guide 1: For local authorities, schools and early years providers, workplaces and the public).

2.9 Further NICE guidance relevant to this particular aspect of the inquiry has been identified (relating to promoting and creating built or natural environments that encourage and support physical activity) and is attached at Appendix 2 for information and/ or coniseration.

3.0 **The role of the Council and its partners in promoting good public health: Session 2 – continued**

3.1 In line with the agreed terms of reference, the aim of this part of the inquiry is to consider issues associated with reversing the rise in levels of obesity and promoting an increase in the levels of physical activity, such as:

- The role of the Council and its NHS health partners in developing and delivering appropriate strategies that:
  - Raises general public awareness of the health risks associated with obesity and inactive lifestyles.
  - Identifies and targets those groups most at risk of becoming obese and leading inactive lifestyles.
  - Assesses the quality and effectiveness of services and treatments associated with obesity.
  - Promotes easy access to leisure facilities and activities.
- The role of the Council in terms of its power of well-being through planning policies and associated enforcement/ control procedures.
- The role of commercial sector partners in promoting healthier lifestyles.

3.2 Given the main focus at the previous session, it is proposed that this meeting focuses more specifically on the work and priorities of NHS Leeds in reversing the rise in levels of obesity and promoting an increase in the levels of physical activity. In this regard, the following information is re-presented for the Board's consideration:

- Can't Wait – Leeds Childhood Obesity Strategy (Appendix 3)
- Adult Obesity (Appendix 4)

3.3 Relevant officers from NHS Leeds have been invited to attend the meeting to highlight any specific matters to the Board and to address any specific questions raised.

3.4 Furthermore, a copy of a House of Commons Select Committee Report on Obesity (published in 2004) is attached at Appendix 5.

4.0 Recommendations

4.1 Members are asked to consider the details presented in this report and associated appendices, and those matters discussed at the meeting and:

(i) Identify any specific areas/ issues to be included in the Board's scrutiny inquiry report; and,

(ii) Determine any specific matters where additional information may be required and/or where further scrutiny may be needed.

5.0 Background Documents

Scrutiny Board (Health): *Scrutiny Inquiry: The role of the Council and its partners in promoting good public health (Session 2)* (15 December 2009)

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Improvement Priorities

Improvement priorities

The agreed improvement priorities for health and wellbeing are:

1. Reduce premature mortality in the most deprived areas.
2. Reduce the number of people who smoke.
3. Reduce alcohol related harm.
4. Reduce rate of increase in obesity and raise physical activity for all.
5. Reduce teenage conception and improve sexual health.
6. Improve the assessment and care management of children, families and vulnerable adults.
7. Improve psychological, mental health, and learning disability services for those who need them.
8. Increase the number of vulnerable people helped to live at home.
9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives.
10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk.

Notes

For each improvement priority the attached table gives the following information:

- the jointly accountable directors, the key partnerships, strategic leads and the related strategies;
- the national indicators and targets together with the measures of success that are being used;
- an overview of the main areas for action over the next three years. This is not intended to duplicate the detailed individual strategies and action plans which are signposted so that further details can be found.

These action plans will inform the performance management process for the Leeds Strategic Plan. The action plans and outcomes will be reviewed and updated annually. Following a preliminary Equality Impact Assessment in April 2009, further work will be undertaken to define issues and actions for the different equality strands (race, gender, disability, sexual orientation, age, religion or belief.) This process will be informed by continuous self-assessment and developments will be formally included in the annual refresh.

1. Reduce premature mortality in the most deprived areas

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup **Rosemary Archer/Sarah Sinclair** Children Leeds Integrated Strategic Commissioning Board	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum Natural England West Yorkshire Fire and Rescue Service
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council Sharon Yellin, NHS Leeds	**Infant Mortality Action Plan 2009** **Leeds The Leeds Children and Young People's Plan 2009 to 2014** **Leeds Tobacco Control Strategy 2006 to 2010** **Food Matters: a food strategy for Leeds 2006 to 2010** **Active Leeds : a physical activity strategy 2008 to 2012** **Accident Prevention Framework 2008 to 2011** **Older Better 2006 to 2011** **Alcohol Strategy 2007 to 2010** **Self Care Strategy 2009** Leeds Housing Strategy 2009 to 2012 Leeds Affordable Warmth Strategy 2007 to 2016 Leeds Financial Inclusion Project

1. Reduce premature mortality in the most deprived areas

Indicators and targets	Measures of success
NI 120 All Age All Cause Mortality rate per 100,000 Disaggregated to narrow the gap between 10% most deprived SOAs and all of Leeds) **Baseline 2001 -2003** *(for population living in 10% most deprived SOAs)* Men Women 1178 692 **3 year target trajectory for 2010 -2012** *(for population living in 10% most deprived SOAs)* Men Women 918 602 *For Leeds as a whole* Men Women 662 463 Citywide target 472 per 100,000 **NI 121 Mortality rate from circulatory diseases at ages under 75 (per 100,000 population)** Baseline 145 per 100,000 population (1995-7) Target 69.3 per 100,000 population (2010-11)	• Further reduction in the proportion of children living in poverty • 1200 families in fuel poverty will have been referred into a programme for improving warmth in their home • Wider availability of quality, affordable housing • Clear city wide framework for development in place and clear expectations for community provision fulfilled in deprived areas. • Improved learning outcomes and skill levels • More engaged and informed better designed programmes **By 2013 in Leeds as a whole:** • 603 people will have been prevented from having an early death • The infant mortality rate will have been reduced from 8 deaths per 1000 to 7 per 1000 • 75,000 women will have been screened for breast cancer. • All women in Leeds will be receiving cervical screening results in 14 days • We will have reduced the number of people under 75 dying from Cardio Vascular Disease by 269 • 349,000 People aged over 40 will have had a vascular check of whom 70,000 People will receive clinical interventions to reduce their risk of becoming unwell **By 2013 in the most deprived areas of Leeds** • 344 people will have been prevented from having an early death • 147 lives will be saved from people under 75 dying from cancer • 109,000 people aged over 40 will have had a vascular check of whom 22,000 will receive clinical interventions to reduce their risk of becoming unwell • We will have prevented 157 people under the age of 75 from dying prematurely from Cardio Vascular Disease **In the most deprived areas of Leeds** • increased percentage of people who are successful in achieving lifestyle behaviour changes (weight management/healthy eating/ smoking cessation/alcohol harm reduction/increased physical activity) • increased percentage of people who engage with local processes and feel they can influence decisions in their locality • environment created for a thriving third sector

1. Reduce premature mortality in the most deprived areas

High Level Actions 2009 - 2012

Influences on health:

- Develop and expand our programme of work on key influences on health such as housing, low income, skills and employment, transport system and the availability of facilities for people to be active.
- Issue a revised housing strategy aimed at creating opportunities for people to live independently in quality and affordable housing.
- Implement fuel poverty action plan and co-ordinate other winter deaths initiatives.
- Promote financial inclusion adapted to the effects of recession.
- Develop a strategic Child Poverty action plan delivering a range of coordinated services to enable families to move out of poverty.
- Improve access to quality early years resources.
- Improve educational achievement for children and young people in disadvantaged areas and from vulnerable groups.
- Complete Planning Policy Guidance 17 - 'Planning for open space, sport and recreation' assessment, ensuring that gaps in provision are identified and appropriate standards for new facilities are implemented.

Lives people lead:

- Action on key behaviour changes which have a high impact on life expectancy; these to include providing systematic brief interventions; marketing materials and peer / community engagement.
- Develop work around smoking, targeted at the worst 10% deprived neighbourhoods *(see Improvement Priority 2)*.
- A targeted programme of work around alcohol *(see Improvement Priority 3)*
- Programmes addressing obesity, physical activity and healthy eating *(see Improvement Priority 4)*.
- Promote Healthy Ageing with the direct involvement of older people.

Services people use:

- Develop Healthy Living services within neighbourhoods (weight management/smoking cessation/alcohol brief interventions/health trainers) and broader poverty/well being services.
- Implement a comprehensive social marketing approach to Putting Prevention First (vascular check for those between 40-75).
- Interventions to target circulatory diseases including increasing the number of smoking quitters and improved blood pressure and cholesterol control.
- Develop an action plan to ensure equitable access to primary care services for vulnerable groups.
- Work with Practice Based Commissioning to ensure these high impact interventions happen in the 10% most deprived neighbourhoods.
- Implement the Self Care Framework to ensure that individuals are enabled, empowered and supported to self care and that professionals have the relevant knowledge and expertise to promote and deliver self care approaches.
- Develop a programme of initiatives at LTHT in order to utilise that setting to address issues around alcohol, smoking and weight management, and to ensure the equitable provision of CHD, cancer and respiratory care secondary services.
- Develop targeted cancer programmes and increase uptake and awareness in areas of low uptake, high deprivation and within vulnerable groups.
- Implement the Leeds Strategic Maternity Matters and Infant Mortality Action Plans and associated initiatives.

Community development and involvement:

- Develop local infrastructures where partners engage with residents, particularly those 'seldom seen, seldom heard' in services.
- Involve communities, groups and individuals in the preparation and, when appropriate, delivery of health improvement programmes.
- Improve health literacy and provide motivation and support for appropriate health-seeking behaviour.
- Support growth and development of quality local services and community development by the Voluntary, Community & Faith sector.

2. Reduce the number of people who smoke

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council	**Leeds Tobacco Control Strategy 2006 to 2010** **The Leeds Children and Young People's Plan 2009 to 2014** **Infant Mortality Action Plan 2009**

2. Reduce the number of people who smoke

Indicators and targets	Measures of success
NI 123 Stopping smoking (target disaggregated to narrow the gap between 10% most deprived SOAs and the rest of Leeds)	• contribute to the overall reduction in adult and infant mortality rates and to increasing life expectancy by - helping 22,000 people to stop smoking by 2013 - Protecting non-smokers
Baseline (2004) 31% smokers in the Leeds population	• Increase in the rate of smoking cessation in women of child bearing age • Reduce smoking in pregnancy rate by 2 percentage points by 2010 • Increase in the rate of prisoners who quit smoking with NHS Stop Smoking Services in the prison setting
Target (2010-11) 21% smokers in the Leeds population 27% smokers in 10% most deprived SOAs	• By 2013 in practices with 30% or more of their population living in the 10% most deprived SOAs: 7% of registered smokers will be referred to smoking services per year
Vital signs VSB05 4 weeks smoking quitters who attended NHS Stop Smoking Services.	• There will be community based healthy living programmes and activities available in the 50% of the 10% SOAs by 2013
Target 2010/11 4345 people stopping smoking with NHS Stop Smoking Services	

2. Reduce the number of people who smoke

High Level Actions 2009 - 2012

Influences on health:

- Make sure that local capacity for delivery of the tobacco programme and tobacco control is strengthened and sustained.
- Maintain compliance across the city with smoke free legislation.
- Maintain and promote smoke free environments not included within the boundaries of smoke free legislation.
- Contribute to, and develop, local response to national and regional media campaigns to promote all elements of tobacco control work including: access to support for smoking cessation, promotion of smoke free homes and campaigns to reduce the availability of smuggled and illicit tobacco products.
- Gather and use comprehensive data (e.g. prevalence among the general population, specific target groups such as pregnant women and access to smoking cessation services) to inform tobacco control and commissioning of smoking cessation services.

Lives people lead:

- Review the schools pilot programme to reduce uptake of smoking amongst teenagers, further develop if necessary and deliver particularly in the most deprived areas.
- Deliver high impact actions to reduce smoking before, during and after pregnancy, including:
  - Promoting smoking cessation to women of child bearing age and link with the city wide infant mortality action programme.
  - Reaching pregnant smokers as soon as possible and throughout pregnancy.
  - Supporting pregnant women to stop smoking throughout pregnancy.
- Explore the feasibility of extending smoke free to public areas.
- Further extend the Smoke Free Homes Project, particularly in the most disadvantaged areas.

Services people use:

- Commission further smoking cessation services in new settings to increase the accessibility of services including: hospitals, workplaces and prisons.
- Focus the specialist element of services in the most deprived communities.
- Review current stop smoking services for specific groups e.g. South Asian Communities, pregnant women and consider recommendations for further development.
- Work with health care professionals to ensure the issue of smoking is raised in a systematic and routine manner and effective referral pathways are developed and maintained.

Community development and involvement:

- Develop work with communities around reducing accessibility to tobacco products and particularly counterfeit and smuggled tobacco products.
- Commission Voluntary, Community and Faith sector to deliver Healthy Living Activity that includes signposting to smoking cessation support and the provision of activities to support behaviour change.
- Engage service users and potential service users in the development of community based delivery of smoking cessation interventions.

3. Reduce alcohol related harm

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene / Neil Evans Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup Safer Leeds/ Healthy Leeds Alcohol Board	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust Voluntary, Community and Faith sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council Jim Willson, Leeds City Council	**Leeds Alcohol Strategy 2007 to 2010** **Safer Leeds Partnership Plan 2008 to2011** The Leeds Children and Young People's Plan 2009 to 2014

3. Reduce alcohol related harm

Indicators and targets	Measures of success
NI 39 Hospital admissions for alcohol related harm Reduce the increase in the rate of alcohol-related hospital admission by at least 1% per year	• Reduced economic loss due to alcohol • Increased understanding of the culture of alcohol use across the population of Leeds • Reduced number of prisoners needing alcohol detoxification programmes in prisons • Fewer people will perceive drunk and rowdy behaviour to be a problem • Reduced alcohol-related harm experience among children, young people and families • Reduction in alcohol-related crime and disorder and hospital admissions

3. Reduce alcohol related harm

High Level Actions 2009 - 2012

Influences on health:

- Reduce the rate of alcohol related crime and disorder, anti-social behaviour and domestic abuse.
- Promote responsible management of licensed premises through effective implementation of the Licensing Act 2003 and encourage the licensing authority to consider safeguarding issues for children and young people.
- To have data in place that will be able to demonstrate:
  - the alcohol related recorded violent crime;
  - the percentage of cases where alcohol use is linked to offending;
  - the percentage of domestic violence where alcohol is a contributing factor;
  - the use of alcohol in young people aged under 18; and
  - the rate of alcohol- specific hospital admissions in under 18s.
- Tackle domestic violence linked to the misuse of alcohol.

Lives people lead:

- Improve the quality of, and have a consistent approach to, alcohol education provision in school and non-educational settings.
- Enable parents and carers to discuss the issue of alcohol consumption with their children.
- Target vulnerable children (i.e. those excluded from school) and work with youth services.
- Ensure that support is available, in terms of housing, to those who misuse alcohol.
- Develop a communication plan about alcohol so that the population of Leeds can make informed choices about their alcohol use and shift attitudes to harmful drinking.
- Target high-risk health settings, such as primary care, A&E departments, mental health settings, sexual health settings, maternity services and older people's services.
- Provide individuals who want, or need, to reduce their alcohol consumption with self-help guides.
- Promote activity and policy change towards reducing the promotion, accessibility and availability of alcohol.
- Implement the National Youth Alcohol Action plan.

Services people use:

- Promote a model of prevention which fully addresses alcohol issues throughout the education system.
- Increase the number of staff working in health, social care, criminal justice, community and the voluntary sector who are trained to identify alcohol misuse and offer brief advice.
- Develop strategies for prisoners in Leeds district with alcohol related problems.
- Develop a programme of activities to reduce the level of alcohol related health problems, including alcohol related injuries and accidents, and to improve facilities for treatment and support.
- Ensure that a co-ordinated, stepped programme of treatment services for people with alcohol problems is effective, appropriate and accessible, with adequate capacity to meet demand, following the 4 tiered framework from Models of Care for Alcohol Misusers
- Increase in the number of high risk groups (offenders, people with mental health conditions, people admitted to A&E and/or hospital with alcohol-related disease) who are assessed, offered brief interventions and where appropriate referred to alcohol treatment services.
- Have a well informed workforce equipped to provide information on the effects of substance misuse, including smoking.

Community development and involvement:

- Develop work with communities around reducing promotion and accessibility of alcohol products.
- Develop the young people led alcohol minimisation action plan.
- Ensure commissioning of Voluntary, Community and Faith sector around healthy living activity includes signposting to services that support reduction in alcohol harm and the provision of activities to support behaviour change.
- Engage service users and potential service users in the developing community based delivery of alcohol treatment interventions.

4. Reduce rate of increase in obesity and raise physical activity for all

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board **Ian Cameron / Sandie Keene** Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**Leeds City Council** Children Leeds Partners NHS Leeds Sport England Education Leeds Youth Sports Trust VCFS Sector
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Sarah Sinclair, NHS Leeds/ Leeds City Council John England, Leeds City Council Brenda Fullard, NHS Leeds	**Active Leeds : a Healthy City 2008 to 2012** **Taking the Lead: strategy for sport and active recreation in Leeds 2006 to 2012** **Food Matters: a food strategy for Leeds 2006 to 2010** **Leeds Childhood Obesity Strategy 2001 2016** **Adult Obesity Strategy (in preparation)** **Leeds School Meals Strategy Jan 2007** **The Leeds Children and Young People's Plan 2009 to 2014** Local and West Yorkshire Transport Plans & Cycling Strategy Parks and Green Space Strategy 2009 Leeds Play Strategy 2007 Older Better 2006 to 2011

4. Reduce rate of increase in obesity and raise physical activity for all

Indicators and targets	Measures of success
NI 57 Children and young people's participation in high quality PE and sport Baseline 91% 2007/08 Target 93% 2009/10' **NI 8** Adult participation in sport and active recreation Baseline 20.6% 2005/06 Target 21.6% March 2011	• Halt, by 2010 (from the 2002-04 baseline) the year-on-year increase in obesity among children under 11 • Reduce rate of increase in obesity in adults • More children eating healthily and participating in play, cultural activities and quality physical exercise programmes • More people of all ages participating in walking, cycling and general activities • Increase in the number of disabled people accessing sport and active recreation programmes • Improved uptake of quality sport and active recreation opportunities including those provided by provided by Leeds City Council Sport and Active Recreation Service, • Increased number of people who have an average consumption of a variety of fruit and vegetables of at least five portions per day • More mothers breastfeeding (2% annual increase) • Systematic health checks are provided in primary care for childhood and adult obesity linking to interventions provided by a variety of providers • Increase in accessible weight management services, targeted to those already obese and most at risk • More people (including older people and disabled people) taking up healthy living opportunities in care programmes or self-directed care • Developed programmes to increase physical activity levels in priority areas

4. Reduce rate of increase in obesity and raise physical activity for all

High Level Actions 2009 - 2012

Influences on health:

- Ensure that planning for the built environment, green spaces and transport encourage a more active lifestyle, complemented by attention to disability issues and to safety.
- Introduce flexibilities in planning arrangements and urban design to manage the proliferation of fast food outlets and tackle issues of poor food access.
- Complete Planning Policy Guidance 17 - 'Planning for open space, sport and recreation' assessment, ensuring that gaps in provision are identified and appropriate standards for new facilities are implemented.
- Implement the delivery plan for the 'Active Leeds: a Healthy City' strategy.
- Ensure a co-ordinated approach to food work to develop effective communication and promote consistent healthy eating messages using principles of social marketing.
- Work with employers to promote healthy eating (including LCC / NHS Leeds) and business sign up to healthy workplace programmes.
- Increased achievement of Healthy Food Mark Standard or equivalents.
- Ensure the public sector addresses issues of healthy eating, safe and sustainable food and malnutrition within its catering arrangements and food provision.

Lives people lead:

- Ensure regular physical activity is sustained beyond 16 years+.
- Increase the number of trips made by walking and cycling ensuring that safety is taken into account.
- Increase the number of older people taking part in regular physical activity.
- Expand opportunities for disabled people to lead an active life.
- Improve people's ability to choose and obtain healthy food that meets nutritional requirements that are right for their stage of life.
- Commission healthy eating cooking skills and food access programmes for targeted neighbourhoods and community groups.
- Use the National Change 4 Life social marketing programme to support and empower people to make changes to diet and activity.
- Develop and implement Leeds Strategic Maternity Matters action plan and Breastfeeding Strategy.

Services people use:

- Ensure there are appropriate pathways to identify and manage overweight and obese individuals linking to a variety of agencies.
- Invest in Putting Prevention First programmes in primary care.
- Developing healthy living services within neighbourhoods including weight management services.
- Develop further joint health and physical activity programmes for people experiencing poor health, or in danger of developing poor health to change their lifestyles and become healthy.
- Develop and implement a range of physical activity training programmes and opportunities including free swimming for young people and older people from April 2009.
- Develop healthy eating programmes within priority neighbourhoods and encourage adoption of healthy eating principles in community based facilities (all sectors).
- Implement School Meals and Packed Lunch strategies.
- Promote the use of Active Leeds Physical Activity Tool Kit.
- Ensure a proactive workforce with knowledge and skills to address healthy behaviour change including using consistent messages around behaviour change, healthy weight, balanced diet and physical activity.
- Embed the practice of screening for malnutrition in facilities and in the community by health, social care and community service providers and professionals.
- Support a range of organisations to promote and provide practical support around health lifestyle messages around being a healthy weight, eating a balanced diet and increasing physical activity.

Community development and involvement:

- Ensure user involvement in the development and continuation of all programmes and services relating to food, physical activity and weight management.
- More participants in food and exercise activities commissioned from local organisations especially in target areas.
- Voluntary, Community and Faith sector agencies commissioned to develop physical activity opportunities within a community development approach.

5. Reduce teenage conception and improve sexual health

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board – Teenage Pregnancy and Parenthood Board **Ian Cameron / Sandie Keene** Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**Leeds City Council** Children Leeds Partners NHS Leeds Education Leeds Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Sarah Sinclair, NHS Leeds/ Leeds City Council Victoria Eaton, NHS Leeds John England, Leeds City Council	**Teenage pregnancy and parenthood strategy 2008 to 2011** **Sexual health strategy 2009 to 2014** The Leeds Children and Young People's Plan 2009 to 2014 Alcohol Strategy 2007 to 2010

5. Reduce teenage conception and improve sexual health

Indicators and targets	Measures of success
NI 112 Under 18 conception rate *disaggregated to focus on the 6 wards in the city with the highest rates of conception* **Baseline (1998)** 50.4 per 1000 girls aged 15-17 **Leeds 2006 rate** 50.7 per 1000 girls aged 15-17 **Target (2009/10)** Target rate 42.7 per 1,000 girls aged 15-17 *Based on 15% reduction in 6 wards with highest conception rate* **Vital Signs** Guaranteed access to a GUM clinic within 48 hours of contacting a service	• Fewer unplanned pregnancies • Gonorrhoea infections reduced by 15% • Fewer girls under 18 conceiving • 217,000 people aged 15 – 24 will have been screened for Chlamydia • 10% increase year on year in number of STI and HIV tests in non GUM settings • 90% of gay men accessing all sexual health services will receive a hepatitis B vaccine

5. Reduce teenage conception and improve sexual health

High Level Actions 2009 - 2012

Influences on health:

- Campaigns to target the general population of Leeds to reduce stigma related to sexual health.
- Increase positive work with the local media.

Lives people lead:

- Develop a communications plan for both young people, adults and professionals and links between sexual health and teenage pregnancy work.
- Develop local teenage pregnancy data and set up system for sharing data across agencies.
- Review existing provision of Sex and Relationship Education within educational and non-educational settings.
- Increase parents' confidence to discuss sexual health and relationship issues.
- Review impact of transition from Youth Service Health Education Team to generic services.
- Deliver programme of improving skills, knowledge, confidence, aspirations and empowering the most vulnerable to sexual health.
- Increase programmes developing skills and knowledge of gay men, young people and African and African Caribbean communities.
- Support the health and wellbeing for those living with HIV and AIDS.

Services people use:

- Ensure access to local services that are integrated, holistic and sensitive and appropriate to people from different backgrounds.
- Develop single access point for all sexual health services.
- Increase access to and improve knowledge of contraception.
- Increase access to emergency contraception and improve the uptake of contraception post pregnancy or terminations.
- Support for parents and carers on talking to children about sex and relationship issues at Children's Centres.
- Expand the Chlamydia screening programme.
- Ensure screening programmes are accessible and acceptable to target groups.
- Ensure prevention is integral to all clinical services.
- Increase HIV testing in a range of settings.
- Increase service provision in deprived areas, through GP practices, pharmacies, prisons.
- Improve the skills and knowledge of professionals in offering all forms of contraception and STI and HIV testing, STI treatment and sex and relationships education.
- Increase access to HIV treatment for gay men and African communities.
- Review existing services against the needs and identify gaps.

Community development and involvement:

- Increase community based and outreach initiatives with vulnerable groups.

6. Improve the assessment and care management of children, families and vulnerable adults

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board **Sandie Keene / Jill Copeland** Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group	**Leeds City Council** NHS Leeds Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum Children Leeds partners
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Jackie Wilson, Leeds City Council Dennis Holmes Leeds City Council Carol Cochrane, NHS Leeds	**Adult Social Care Service Plans** **The Leeds Children and Young People's Plan 2009 to 2014** **Putting People at the Centre (Learning Disability Strategy) 2009 to 2012** Carers Strategy for Leeds 2009

6. Improve the assessment and care management of children, families and vulnerable adults

Indicators and targets	Measures of success
NI 132 Timeliness of social care assessment (all adults) Baseline 80.9% 2010-11 Target 90.0% 2007 **NI 133** Timeliness of social care packages following assessment (all adults) Baseline 85% 2010-11 Target 95.0% **NI 63** Stability of placements of looked after children: length of placement Baseline 70.5% 2010-11 Target 80.0% **NI 66** Looked after children cases which were reviewed within required timescales Baseline 60.2% 2009-10 Target 90.0%	• More people, especially with long term conditions, are able to lead independent lives • Appropriate support for vulnerable adults • Carers receive appropriate and timely support • Improved patient and carer experience • Young adults are fully supported in transitions between services, especially on entering adulthood

6. Improve the assessment and care management of children, families and vulnerable adults

High Level Actions 2009 - 2012

Lives people lead:

- Improve the awareness of the needs of carers.
- Increase the number of carers who receive a health check.

Services people use:

- Provide efficient and effective out of hours service and redesign care management process.
- Reduce delayed transfers of care.
- Improve outcomes for people from BME backgrounds.
- Improve outcomes for people with personality disorders.
- Improve outcomes for young people who have committed offences.
- Ensure arrangements are in place for protecting vulnerable people from abuse through improved assessment and care management.
- Implement self directed support pilot for the full range of client groups.
- Improve care planning for young people in transition by creating a joint team from both Children's and Adult Social Care.
- Embed the Common Assessment Framework for children and young people in Children's Services to provide early assessment and multi-agency actions centred around individual children and young people's needs.
- Undertake regular reviews for vulnerable people and their carers.

Community development and involvement:

- Involve and engage service users and carers.
- Involve voluntary, community and faith sector.
- Ensure the availability of advocacy for vulnerable people.

7. Improve psychological, mental health, and learning disability services for those who need them

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Rosemary Archer** Children Leeds Integrated Strategic Commissioning Board	**Leeds City Council** NHS Leeds Leeds Partnership Foundation NHS Trust Children Leeds Partners Leeds Colleges VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Leeds Mental Health Strategy 2006 to 2011** **Leeds Emotional Health Strategy 2008 to 2011 (CYP)** **Putting People at the Centre (Learning Disability Strategy) 2009 to 2012** **Social Inclusion and Mental Health Strategy (in preparation)** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009

7. Improve psychological, mental health, and learning disability services for those who need them

Indicators and targets	Measures of success
NI 58 Emotional and behavioural health of looked after children (new indicator) **NI 130** Social Care Clients receiving self-directed support Target 30% take up of self directed support options by March 2011 **VSCO2** Proportion of people with depression and/or anxiety disorders who are offered psychological therapies. Targets and milestones to be determined by March 2009	• People from all backgrounds get timely and appropriate care • Individuals feel valued and included • Improved access to appropriate housing for vulnerable groups • Learning disabled people enjoy better health • Learning disabled people with complex health needs receive effective and person centred treatment care and support provided locally • Learning disabled people and their carers benefit from accessible and person centred services with specialist health supports in primary and secondary care • More people using and enjoying mainstream facilities • Evidence of more personalised care and support • Earlier intervention to reduce risk of crisis • More rapid and effective recognition and support for people suffering anxiety and depression. • Number of people accessing dementia services

7. Improve psychological, mental health, and learning disability services for those who need them

High Level Actions 2009 - 2012

Influences on health:

- Reduce stigma and discrimination.
- Increase opportunities to access employment and meaningful education.
- Improve access to arts and leisure activities.
- Ensure vulnerable groups to have access to a range of housing opportunities.

Lives people lead:

- Develop services from community based locations with partners and reduce reliance on use of segregated buildings.
- Increase choice and control in support including increasing the take up of self directed support and individualised budgets.
- Implement Mental Health First Aid training for employers.
- Recognise needs of more mobile population by providing appropriate support including city centre changing places.

Services people use:

- Undertake options appraisal of models of integrated care.
- Transform mental health and learning disability day services.
- Ensure people with learning disabilities have health checks and Health Action Plans.
- Develop capacity of primary and secondary health services to meet the needs of people with learning disabilities.
- Improve access, uptake and information on health and health services, by developing accessible information.
- Review specialist health services for people with learning disabilities with continuing treatment needs and develop service model.
- Implement Independent Living Project to promote social inclusion through procuring a range of housing options in local communities and transforming care and support services.
- Development of Primary Care Mental Health Services to eradicate age discrimination.
- Joint Transitions Team for children & young peoples social care and adult social care in place by March 2010.
- Implementation of Dual Diagnoses Strategy (substance use and mental health).
- Expand services in primary care to increase access to psychological therapies for people with common mental health problems.
- Improve access to early intervention services.
- Improving public and professional awareness of Dementia.
- Improve early diagnosis and intervention for people with Dementia.
- Improved quality of life and support for people with Dementia.
- Develop strategy on autism.

Community development and involvement:

- Increase opportunities to enjoy a range of social activities and networks.
- Continue community development worker service for BME communities.
- Review user carer involvement structures to ensure fitness for purpose.
- Extend network of Dementia Cafés.

8. Increase the number of vulnerable people helped to live at home

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Sandie Keene / Philomena Corrigan** Healthy Leeds Joint Strategic Commissioning Board – Planned and Urgent Care sub-group	**Leeds City Council** Leeds PCT Leeds Partnership Foundation NHS Trust VCFS bodies through Leeds Voice Health Forum West Yorkshire Fire and Rescue Service Leeds Colleges
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Leeds Housing Strategy 2005 to 2010** **Supporting People Strategy 2005 to 2010** **Carers Strategy for Leeds 2009 to 2012** **Older Better Strategy 2006 to 2011** The Leeds Children and Young People's Plan 2009 to 2014

8. Increase the number of vulnerable people helped to live at home

Indicators and targets	Measures of success
NI 141 Percentage of vulnerable people achieving independent living Baseline 2007-8 58.6% Targets 2010-11 76% **NI 139** The extent to which older people receive support they need to live independently at home Baseline and target to be set from Place Survey **NI 136** People supported to live independently through social services (all adults) Baseline (new target) Target 66%	• Fewer inappropriate admissions to hospital • Falls reduced and more people who fall are treated at home • Stroke care pathway improved • People with mental health problems or learning disabilities can access wider range of housing, employment, training and leisure opportunities • Improved choice delivering a personalised service based on individual preferences for vulnerable groups

8. Increase the number of vulnerable people helped to live at home

High Level Actions 2009 - 2012

Influences on health:

- Use a social model approach to challenge the barriers faced by older people and disabled people to independence, inclusion and equality.
- Maintain and promote older people's and disabled people's independence for as long as possible.
- Better access to good quality housing for vulnerable people.

Lives people lead:

- Promote and increase take up of Personal Budgets.
- Increase the number of people with mental health problems and learning disabilities who are in employment , education or in voluntary activity.

Services people use:

- Expand interactive services such as telehealth, broadband/interactive access and telecare.
- Expansion of falls assessment and treatment service.
- Transform learning disability day services currently provided by LCC.
- Redevelopment of Windlesford Green hostel for people with learning disabilities.
- Provision of new, modern accommodation for people with learning disabilities through the Independent Living Project.
- Increase the number of vulnerable people utilising self directed support to deliver their care and support needs.
- Develop and improve information sources to ensure that the communication barriers affecting different groups are overcome.

Community development and involvement:

- Development of self care strategy supported by Health Trainers for people with long term conditions.

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Sandie Keene / Philomena Corrigan** Healthy Leeds Joint Strategic Commissioning Board – Planned and Urgent Care sub-group	**Leeds City Council** NHS Leeds VCFS bodies through Leeds Voice Health Forum and Learning Disability Forum, Older People's Forum, Physical Disability Forum and Volition.
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Adult Social Care Business Plans** **Older Better** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009 to 2012

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

Indicators and targets	Measures of success
NI 130 Social Care Clients receiving self-directed support Target 30% take up of self directed support options by March 2011	• More people aware of and accessing benefit and fuel support • People lead richer and more fulfilling lives whatever their age or condition • Increased satisfaction among service users and carers • Choice and control are enhanced by simpler access with less risk of duplication or gaps • Evidenced access to information, advice and advocacy • Better sharing of information subject to appropriate safeguards • Increased capacity for support within local communities

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

High Level Actions 2009 - 2012

Influences on health:

- Continue work to promote financial inclusion.
- Develop and improve transport which meets people's needs.

Lives people lead:

- Promote Healthy Ageing with the direct involvement of older people, encouraging a positive view of old age and disability.
- Use social marketing to develop information about opportunities, accessible to all groups.

Services people use:

- Roll out of Common Assessment Framework.
- Continue work on the Self-Directed support programme.
- Promote and increase take up of Personal Budgets .
- Deliver services for older people and disabled people that are flexible and accessible and promote choice and control.
- Deliver care and support close to where people live or within their own homes.
- Ensure that older people and disabled people are treated with respect and dignity at all times.
- Take an holistic approach to care and support, joining up different elements across professions and agencies.
- Share good practice across the city, agencies, organisations and professions.
- Develop community support services for people with stroke and other neurological conditions.
- Provide excellent eye health and eye care and sight loss support in an inclusive city.

Community development and involvement:

- Ensure full participation of older people and disabled people in the decisions and processes which affect their lives.
- Enable older people and disabled people to lead an active and healthy life and be involved as citizens of the city.
- Tackle social isolation of older people .

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board - Children Leeds Safeguarding Board **Sandie Keene / Jill Copeland** Healthy Leeds Joint Strategic Commissioning Board -Adult Safeguarding Board	**Leeds City Council** Education Leeds NHS Leeds Children Leeds Partners VCFS bodies through Leeds Voice CYP Forum and Health Forum Leeds Colleges
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council Sarah Sinclair, NHS Leeds/ Leeds City Council	**Adult Safeguarding Strategy** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009 to 2012

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

Indicators and targets	Measures of success
Number of children looked after *(expressed as a rate per 10,000 excluding unaccompanied asylum seekers)* Baseline 83.6 Target 2020-11 59.1 Estimated number of staff employed by independent sector registered care services in the council area that have had some training on protection of adults whose circumstances make them vulnerable that is either funded or commissioned by LCC - Target to be set following calculation of baseline	• Wider awareness of issues among staff and in wider communities • Risk factors are managed consistently and effectively • Arrangements for safeguarding vulnerable children and adults are effective across agencies and disciplines. • Everyone involved in safeguarding has the appropriate knowledge, skills and understanding

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

High Level Actions 2009 - 2012

Influences on health:

- Increase overall awareness of safeguarding issues through communications and social marketing.

Lives people lead:

- Implement consistent assessment procedures for risk, mitigation and management.

Services people use:

- Ensure high quality safeguarding practice is embedded across partners.
- Revise and implement multi-agency adult safeguarding procedures.
- Implement mandatory specialist safeguarding training programme.
- Implement work programme of adult safeguarding board.
- Jointly appoint head of adult safeguarding.
- Establish practice standards and competencies.
- Ensure the work of the safeguarding adults partnership board is informed by the views and experiences of all stakeholders
- Improve safeguarding arrangements for children.

Community development and involvement:

- Increase general awareness of safeguarding issues and secure community support.
- Increase general awareness of capacity issues and secure community support.

Related plans

Plan title	Internet link (click to open)
NHS Leeds Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13970
Leeds Alcohol Strategy 2007 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13938
Older Better 2006 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13958
Leeds Housing Strategy 2009 to 2012	(under development)
Supporting People Strategy 2005 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13956
Safer Leeds Partnership Plan 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13960
Active Leeds: a Healthy City 2008 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13932
Leeds Food Matters 2006 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13946
Leeds Tobacco Control Strategy 2006 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13968
Infant Mortality Action Plan 2009	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13948
Accident Prevention Framework 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13930
Self Care Strategy 2009	(under development)
Leeds Affordable Warmth Strategy 2007 to 2016	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13934
Leeds Financial Inclusion Project	http://www.leeds.gov.uk/page.aspx?pageidentifier=cd4994f5-87a4-4935-858b-89e8a360643a
Taking the Lead 2006 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13964
Leeds Childhood Obesity Strategy 2006 to 2016	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13942
Leeds School Meals Strategy	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13954
Adult Obesity Strategy	(under development)
Local and West Yorkshire Transport Plans and Cycling Strategy - various	http://www.leedsinitiative.org/transport/page.aspx?id=2410
Parks and Green Space Strategy 2009	(under development)
Teenage Pregnancy and Parenthood Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13966
Sexual Health Strategy 2009 to 2014	(under development)
Carers' Strategy for Leeds 2009 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13940
Leeds Social Inclusion and Mental Health Strategy 2006 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13962
Leeds Emotional Health Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13944
Putting People at the Centre (Learning Disability) Strategy 2009 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13952
Adult Safeguarding Strategy	(under development)
The Leeds Children and Young People's Plan 2009 to 2014	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=14160

National Institute for Health and Clinical Excellence

Issue Date: January 2008

Promoting and creating built or natural environments that encourage and support physical activity

NICE public health guidance 8

NICE public health guidance 8
Promoting and creating built or natural environments that encourage and support physical activity

Ordering information
You can download the following documents from www.nice.org.uk/PH008

- The NICE guidance (this document) which includes all the recommendations, details of how they were developed and evidence statements.
- A quick reference guide for professionals and the public.
- Supporting documents, including an evidence review and an economic analysis.

For printed copies of the quick reference guide, phone the NHS Response Line on 0870 1555 455 and quote N1444.

This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

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Introduction

The Department of Health (DH) asked the National Institute for Health and Clinical Excellence (NICE or the Institute) to produce public health guidance on the promotion and creation of physical environments that support increased levels of physical activity.

The guidance is for NHS and other professionals who have a direct or indirect role in – and responsibility for – the built or natural environment. This includes those working in local authorities and the education, community, voluntary and private sectors. It may also be of interest to members of the public.

The guidance complements and supports, but does not replace, NICE clinical guidelines on obesity (for further details, see section 7).

The Programme Development Group (PDG) has considered reviews of the evidence, an economic appraisal, stakeholder comments and the results of fieldwork in developing these recommendations.

Details of membership of the PDG are given in appendix A. The methods used to develop the guidance are summarised in appendix B. Supporting documents used in the preparation of this document are listed in appendix E. Full details of the evidence collated, including fieldwork data and activities and stakeholder comments, are available on the NICE website, along with a list of the stakeholders involved and the Institute's supporting process and methods manuals. The website address is: www.nice.org.uk

This guidance was developed using the NICE public health programme process.

Contents

1 Recommendations

This document is the Institute's formal guidance on promoting and creating built or natural environments that encourage and support physical activity. When writing the recommendations, the PDG (see appendix A) considered the evidence of effectiveness (including cost effectiveness), fieldwork data and comments from stakeholders. Full details are available on the Institute's website at: www.nice.org.uk/PH008

The evidence statements that underpin the recommendations are listed in appendix C.

The evidence reviews, supporting evidence statements and economic appraisal are available on the Institute's website at www.nice.org.uk/PH008

The PDG considers all the recommended interventions are likely to be cost effective.

The PDG also considered whether a recommendation should only be implemented as part of a research programme, where evidence was lacking. For the research recommendations and other gaps in the research, see section 5 and appendix D respectively.

The guidance offers the first national, evidence-based recommendations on how to improve the physical environment to encourage physical activity. It demonstrates the importance of such improvements and the need to evaluate how they impact on the public's health.

The recommendations are aimed at many settings and sectors:

- Recommendations 1, 4, 5 (on land use planning) are relevant when developing regional spatial strategies, local development frameworks and other local plans using, for example 'Policy planning guidance 17' (Office of the Deputy Prime Minister undated).

- Recommendations 1, 2, 3, 4, 5 are relevant when developing local transport plans and guidance using, for example ‘Policy planning guidance 13’ (Office of the Deputy Prime Minister 2001).

All the recommendations are relevant when developing joint NHS and local authority strategies (for example, joint community strategies, access plans and local area agreements). They are also relevant when planning and managing the NHS (including its premises).

Strategies, policies and plans

Recommendation 1

Who should take action?

Those responsible for all strategies, policies and plans involving changes to the physical environment. This includes the development, modification and maintenance of towns, urban extensions, major regeneration projects and the transport infrastructure. It also includes the siting or closure of local services in both urban and rural areas.

What action should they take?

- Involve all local communities and experts at all stages of the development to ensure the potential for physical activity is maximised.

- Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life. Ensure local facilities and services are easily accessible on foot, by bicycle and by other modes of transport involving physical activity. Ensure children can participate in physically active play.

- Assess in advance what impact (both intended and unintended) the proposals are likely to have on physical activity levels. (For example, will local services be accessible on foot, by bicycle or by people whose mobility

is impaired?) Make the results publicly available and accessible. Existing impact assessment tools could be used.

Transport

Recommendation 2

Who should take action?

Those responsible for all strategies, policies and plans involving changes to the physical environment, including local transport authorities, transport planners and local authorities.

What action should they take?

Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads. (This includes people whose mobility is impaired.) Use one or more of the following methods:

- re-allocate road space to support physically active modes of transport (as an example, this could be achieved by widening pavements and introducing cycle lanes)
- restrict motor vehicle access (for example, by closing or narrowing roads to reduce capacity)
- introduce road-user charging schemes
- introduce traffic-calming schemes to restrict vehicle speeds (using signage and changes to highway design)
- create safe routes to schools (for example, by using traffic-calming measures near schools and by creating or improving walking and cycle routes to schools).

Recommendation 3

Who should take action?

Planning and transport agencies, including regional and local authorities.

What action should they take?

Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity. These routes should offer everyone (including people whose mobility is impaired) convenient, safe and attractive access to workplaces, homes, schools and other public facilities. (The latter includes shops, play and green areas and social destinations.) They should be built and maintained to a high standard.

Public open spaces

Recommendation 4

Who should take action?

- Designers and managers of public open spaces, paths and rights of way (including coastal, forest and riverside paths and canal towpaths).
- Planning and transport agencies including regional and local authorities.

What action should they take?

- Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity. They should also be accessible by public transport.
- Ensure public open spaces and public paths are maintained to a high standard. They should be safe, attractive and welcoming to everyone.

Buildings

Recommendation 5

Who should take action?

Architects, designers, developers, employers and planners.

What action should they take?

- Those involved with campus sites, including hospitals and universities, should ensure different parts of the site are linked by appropriate walking and cycling routes. (Campuses comprise two or more related buildings set together in the grounds of a defined site.)

- Ensure new workplaces are linked to walking and cycling networks. Where possible, these links should improve the existing walking and cycling infrastructure by creating new, through routes (and not just links to the new facility).

Recommendation 6

Who should take action?

Architects, designers and facility managers who are responsible for public buildings (including workplaces and schools).

What action should they take?

- During building design or refurbishment, ensure staircases are designed and positioned to encourage people to use them.

- Ensure staircases are clearly signposted and are attractive to use. For example, they should be well-lit and well-decorated.

Schools

Recommendation 7

Who should take action?

Children's services, School Sport Partnerships, school governing bodies and head teachers.

What action should they take?

- Ensure school playgrounds are designed to encourage varied, physically active play.

- Primary schools should create areas (for instance, by using different colours) to promote individual and group physical activities such as hopscotch and other games.

2 Public health need and practice

Physical activity not only contributes to wellbeing, it is essential for good health (DH 2004). Increasing physical activity levels in the population will help prevent or manage over 20 conditions and diseases. This includes coronary heart disease, diabetes, some cancers and obesity. It can help to improve mental health. It can also help older people to maintain independent lives.

In 2004, the DH estimated that physical inactivity in England cost £8.2 billion annually (this included the rising cost of treating chronic diseases such as coronary heart disease and diabetes). It is estimated that a further £2.5 billion each year is spent on dealing with the consequences of obesity. Again, this can be caused, in part, by a lack of physical activity (DH 2004).

Physical activity levels vary according to age, gender, disability, ethnicity and socioeconomic status. (National data on physical activity are not broken down by faith, religious belief or sexual orientation.)

Facts and figures

Adults are recommended to undertake a minimum of 30 minutes of at least moderate-intensity activity on most days of the week (DH 2004). Around 65% of men and 76% of women in England do not achieve this (Joint Health Surveys Unit 2004). Seventy per cent of boys and 61% of girls aged 2–15 years are sufficiently active to meet the recommendations for their age (at least 60 minutes of at least moderate-intensity activity each day). Trends between health surveys for England in 1997, 1998, 2003 and 2004 found small increases in physical activity levels between 1997 and 2004. Between 1999 and 2004 (when the same physical activity questions were included for each survey) there were significant increases in the percentage of adults meeting the national recommendations. However, changes in the way physical activity is measured over time mean that no clear trends can be determined (Stamatakis et al. 2007).

Data from the 'National travel survey' show that the distance people walk and cycle has declined significantly in the last 3 decades (Department for Transport 2007a). The average distance walked, per person per year, has fallen from 255 miles in 1975/76 to 201 miles in 2006. Bicycle mileage for the same years fell from 51 to 39 miles per person per year. However, some of the surveys may not have captured all walking and cycling trips.

Environmental issues

Increasing levels of physical activity is a challenge, not just for those directly involved in public health but for professionals, groups and individuals in many sectors of society. Adults, young people and children can achieve the national recommended levels by including activities such as walking, cycling or climbing stairs as part of their everyday life. However, while individual interventions to promote such activity may be important, they are not the only (nor possibly the main) solution. Other issues, including environmental factors, need to be tackled. As Schmid and colleagues say (1995), 'It is unreasonable to expect people to change their behaviours when the environment discourages such changes'.

For the purposes of this guidance, the environment is defined as: ‘any aspect of the physical (natural) environment or the urban or constructed (built) environment that subconsciously or consciously relates to an individual and their physical activity behaviour’ (Foster and Hillsdon 2004).

Government targets

A more physically active population will help the government to achieve the aims and targets it has set out in the following:

- national service frameworks (NSFs) on coronary heart disease, diabetes, mental health, older people and children
- DH policy documents on physical activity including ‘Choosing activity’ (DH 2005) and ‘At least five a week’ (DH 2004)
- other policies including:
    - the cross-cutting sustainable development strategy 'Securing the future' (Department for Environment, Food and Rural Affairs 2005)
    - ‘Walking and cycling: an action plan’ (Department for Transport 2004)
    - ‘Sustainable communities: building for the future’ (Office of the Deputy Prime Minister 2003)
    - public service agreement (PSA) 12 (improve the health and wellbeing of children and young people). This includes reducing the proportion of overweight and obese children under 11 by 2020. It includes a target for all those aged 5–16 to spend 2 hours a week doing PE and school sport as part of (and outside) the curriculum. That means increasing the numbers taking part from 25% (2002) to 85% by 2008. The Department for Children, Schools and Families (DCSF) leads on this (HM Government 2007a)
    - PSA 18 (promote better health and wellbeing for all). This includes reducing the: rate of all causes of mortality among all age groups; mortality rate for cancer among people under 75

(by 20% by 2010); mortality rate for heart disease, stroke and related diseases among people under 75 (by 40% by 2010). The number of people from poorer backgrounds dying from these diseases (compared to those from better off backgrounds) also has to be reduced. The aim is to reduce this 'health inequalities gap' by at least 6% for cancer and 40% for heart disease, stroke and related diseases, by 2010 (HM Government 2007b)

- PSA 21 (increase the uptake of cultural and sporting opportunities by adults and young people aged 16 and above). One target is to increase adult participation in at least nine sporting or cultural events by 2008. The Department for Communities and Local Government (DCLG) leads on this (HM Government 2007c)
- PSA 22 (deliver a successful Olympic Games in 2012 and a sustainable legacy). One indicator is that, in addition to providing all those aged 5–16 with 2 hours a week of PE and sport, there is an increase in the percentage of those aged 5–19 participating in a further 3 hours a week. The Department for Culture, Media and Sport (DCMS) leads on this (HM Government 2007d)
- PSA 27 (lead the global effort to avoid dangerous climate change). This includes a target to reduce UK net CO_2 emissions by 26–32% by 2020. Measures to achieve this include encouraging more people to cycle and walk. The Department for Environment, Foods and Rural Affairs (DEFRA) leads on this (HM Government 2007e)
- agreements between local authorities, primary care trusts (PCTs) and other partners to increase local physical activity levels.

Physical activity framework

Figure 1 (below) shows the links between national policy, local plans and the types of intervention that can increase levels of physical activity. This comprehensive framework was used to develop the recommendations.

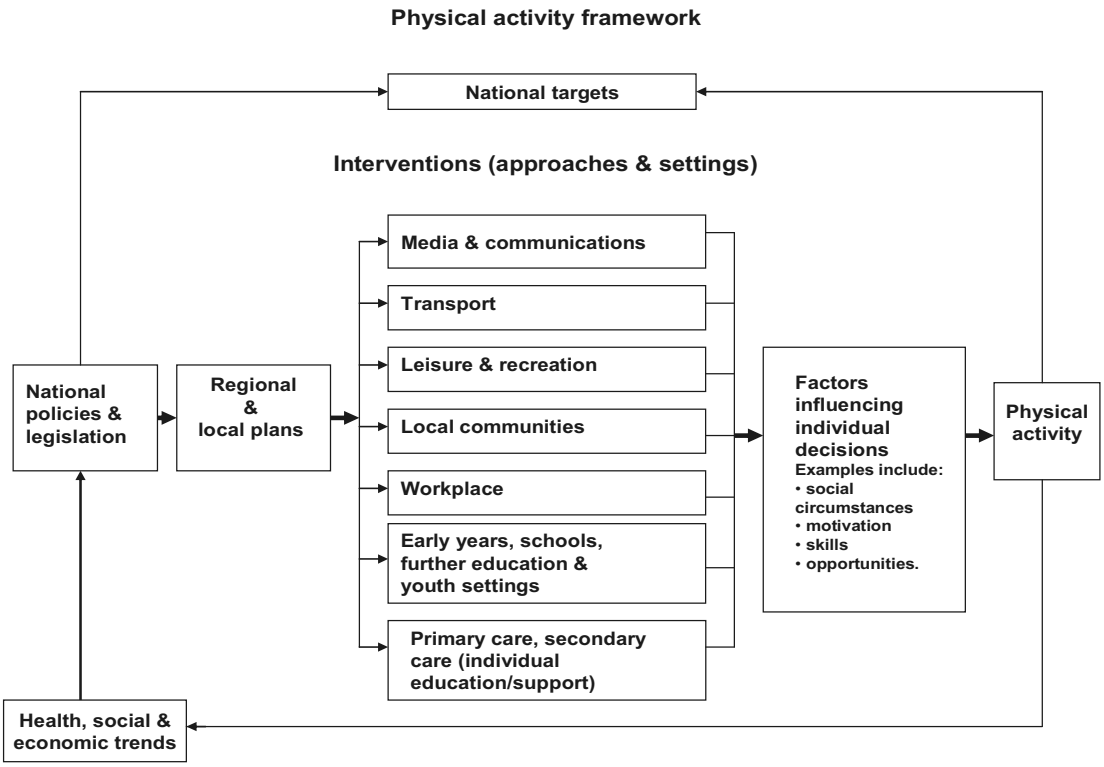

Figure 1

National policies, including 'Choosing activity: a physical activity action plan' (DH 2005), are designed (either implicitly or explicitly) to impact on physical activity levels. 'Choosing activity' asserts that a 'culture shift' is needed if physical activity levels in England are to increase. It commits the government to 'changing the physical and cultural landscape – and building an environment that supports people in more active lifestyles'.

These policies (including cross-government initiatives) are translated into regional and local plans that cover a range of issues including: health, community safety, sustainable development and communities, neighbourhood renewal, social inclusion and transport.

The types of intervention used to support these plans may range from media campaigns (promoting ways of being more physically active) to changes to the physical environment (such as traffic-calming measures or improvements to public open spaces, workplaces and schools).

3 Considerations

The PDG took account of a number of factors and issues in making the recommendations.

3.1 Moderate-intensity activity will usually lead to an increase in breathing and heart rates (to the level where the pulse can be felt) and a feeling of increased warmth. It may also cause the person to sweat on hot or humid days. This level of activity can be achieved during daily life, for example, by walking at a brisk pace (at least 3 miles per hour or 5 kilometres an hour) and cycling. Stair climbing is more likely to be a vigorous-intensity exercise and so may lead to a larger physiological response (a bigger increase in heart and breathing rates). However, it is likely to take place for a shorter length of time.

3.2 Past policy and practice has often – perhaps not intentionally – given priority to sedentary modes of transport and ways of using buildings. Over recent decades, environmental changes in England have made habitual activity less common. Many components of the environment can be modified to make it easier for more people to be physically active. The design and layout of towns and cities can encourage or discourage travel and access on foot or by bicycle. Similarly, building location and design can encourage (or discourage) the use of stairs and other physical activities. These modifications can be achieved by public sector agencies working in partnership with other organisations, including those in the voluntary and community sectors.

3.3 Many organisations own, manage or otherwise influence the space

used routinely by the public and so can influence people's ability to be physically active. (For instance, the location and accessibility of a building can affect whether or not people choose to walk or cycle there). These organisations include public sector landowners and managers (such as local authorities, the education sector and the NHS) as well as private organisations (including businesses) and voluntary sector or non-governmental organisations (NGOs).

3.4 A range of economic, social, cultural and environmental factors influence physical activity levels and the overall impact may be synergistic rather than simply cumulative. While all these factors are important, this guidance focused on changes to the physical environment.

3.5 The PDG noted that a number of interventions use the natural environment to encourage physical activity. Green gyms, where groups are organised to maintain and improve a green space, are one example. This type of project was outside the scope of the guidance because it focused mainly on increasing the physical activity levels of individuals, rather than changing the environment.

3.6 The guidance aims to increase the routine level of physical activity achieved by the population. Individuals need to be capable of activities such as walking or cycling, or have the ability to use a manual wheelchair, to benefit. The PDG recognised that there will always be individuals who cannot, for a variety of reasons, participate. These people require individual support to maintain their mobility and to be as active as possible. Such support was outside the scope of this guidance.

3.7 The recommendations note the importance of getting the community involved to increase physical activity levels (and the need to empower communities to do this). However, it was not part of the PDG's remit to examine how this would be best achieved. Advice will be provided in NICE public health guidance on community

engagement, to be published in February 2008 ('Community engagement to improve health').

3.8 Safety is an important consideration. At the same time, environments that encourage physical activity need to be welcoming, attractive, interesting and even inspirational. It was not within the PDG's remit to consider what might constitute an acceptable level of risk when undertaking physical activity in different settings.

3.9 The five effectiveness reviews carried out for this guidance searched extensively for studies which looked at whether environmental change had altered people's physical activity levels. Out of 94,172 possible papers, 54 studies were finally included in the reviews. However, it was difficult to ascertain to what extent the interventions under examination were responsible for the changes seen because:

- less than 20% used a comparison group
- a substantial number (35) only measured physical activity levels after an intervention
- only a minority used an appropriate, overall measure of physical activity
- follow-up was often short (at around 8 weeks)
- few studies took into account any other factors that might have led to the results
- most studies did not account for the fact that the intervention may have only had an impact on groups that were already active – and may not have affected the population as a whole.

3.10 It is often difficult to interpret physical activity outcomes and to ascribe causality. A change in physical activity levels (an increase or decrease) was often an unintended outcome of the interventions studied and was not usually the main focus of evaluation. In addition, the evaluation process was frequently designed by non-health professionals who may take a different approach to examining the

effects of projects. Specifically, the following evaluation issues were considered by the PDG.

- Physical activity was frequently measured in terms of 'numbers of users' or 'trips'. These were difficult to translate into physical activity levels.

- Much of the evidence considered only one type of physical activity (such as walking or cycling as a mode of transport) making it difficult to determine if there was any overall change in physical activity levels. (For example, someone might be walking more but doing less sport, resulting in no increase – or even an overall decrease – in their level of physical activity.)

- Environmental interventions in one geographical area may have had an unidentified (and potentially negative), knock-on effect in other areas. For instance, reducing traffic speed in some streets may have increased traffic in others, leading to a reduction in the number of people who, for example, walked or cycled in those areas.

3.11 There is a dearth of evidence on how environmental interventions affect the physical activity levels of different groups, so it is not clear what impact the recommendations will have on health inequalities. For example, little is known about how the effects vary in relation to gender, age, ethnicity, culture and religion. In addition, there is little evidence in relation to people with disabilities or according to people’s sexual orientation. The PDG stressed that the impact on local health inequalities must be taken into account when implementing the recommendations.

3.12 Much of the evidence came from non-UK studies undertaken in a limited range of settings and its applicability to the UK needs to be taken into account. In addition, the evidence primarily relates to urban

areas: it is important that planners and delivery agencies also consider and address the needs of people living in rural areas.

3.13 The PDG noted that most of the recommendations reflect current best practice.

3.14 The PDG considered a number of health economics issues.

- Both cost–benefit and cost–utility analyses were carried out. As many interventions were not NHS-based, a cost–benefit analysis (as favoured in transport economics) might be considered more appropriate than the cost–utility analysis generally used in health economics. On the other hand, using the latter meant that these interventions could be compared with health interventions that had been assessed using NICE cost-effectiveness methods.

- As increased physical activity was not the main aim of many interventions studied, it was not clear what proportion of the cost might be attributed to the health benefits arising from a subsequent increase in physical activity levels.

- Many of the recommended changes would probably be carried out anyway (for other purposes). For example, little extra cost is likely to be incurred in designing stairs to encourage people to use them. However, such changes would still incur a small opportunity cost.

3.15 The literature reviews focused on finding links between an intervention and a change in physical activity patterns. Details of how to implement an intervention (for instance, how best to design traffic-calming schemes) were outside the scope of the guidance. Links to examples of best practice such as ‘Manual for streets’ (Department for Transport 2007b) and ‘Active design’ (Sport England 2007) will be provided in the implementation materials.

3.16 When implementing the recommendations, it is important to pay

particular attention to the needs of people whose mobility is impaired. This includes the needs of people with physical disabilities (including wheelchair users), frail older people and parents or carers with small children. This is important, not only to ensure these groups benefit directly, but to get the largest possible increase in physical activity levels across the population as a whole.

3.17 Only interventions that change the physical environment were included within the scope of the guidance. Nevertheless, the PDG stressed the importance of providing information on the benefits of physical activity – and publicising how people can be more physically active. (The latter could be achieved by using posters or stair-riser banners to encourage people to use stairs, and by using posters and leaflets to encourage them to use cycle routes and other physical activity facilities.)

3.18 It is likely that facilities such as secure cycle parking and showers at work could play an important role in helping to encourage people to be active at work. However, the relevance of such facilities was not reported in the literature considered by the PDG.

3.19 Implementation of many of the recommendations (for example, on the siting and design of stairs and in relation to walking and cycling routes) will be subject to existing legislation. The 'Equality act', 'Disability discrimination act' and all other relevant legislation, including that covering fire safety and building design, needs to be taken into account.

3.20 An equality impact assessment (EQIA) of the draft guidance resulted in a number of changes to the final document. For details see appendix E.

3.21 The PDG is aware of the relationship between the lack of physical activity and obesity (see section 2). It is also aware of the government's Foresight programme on obesity (Government Office

for Science 2007). Any targets produced following that document's publication are likely to be relevant to this guidance.

4 Implementation

NICE guidance can help:

- Local authorities fulfil their remit to promote the economic, social and environmental wellbeing of communities.
- National and local organisations within the public sector meet government indicators and targets to improve health and reduce health inequalities.
- Provide a focus for health and wellbeing partnerships, children's trusts and other multi-sector partnerships working on health within a local strategic partnership.
- NHS organisations meet DH standards for public health as set out in the seventh domain of 'Standards for better health' (updated in 2006). Performance against these standards is assessed by the Healthcare Commission, and forms part of the annual health check score awarded to local healthcare organisations.
- NHS organisations and local authorities (including social care and children's services) meet the requirements of the government's 'National standards, local action, health and social care standards and planning framework 2005–2008'.
- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.

NICE has developed tools to help organisations implement this guidance. For details, see our website at www.nice.org.uk/PH008

5 Recommendations for research

The PDG has made the following recommendations to plug the most important gaps in the evidence.

Recommendation 1

Who should take action?

Research councils, research commissioners and funders.

What action should they take?

- Fund studies, based on the most rigorous designs possible, to examine the impact that changes to the physical environment have on physical activity levels. The studies should:
    - include initiatives related to urban planning, transport, the natural environment and building design
    - take account of the needs of rural as well as urban populations
    - examine the cost effectiveness of environmental changes that improve physical activity levels.

- Develop theoretical frameworks and methodologies for evaluating the economic benefits of environmental change to encourage physical activity. These should use methods familiar to those outside the health sector (such as cost-benefit analysis) to allow comparison with other environmental interventions. They should also use methods that allow comparison with other health interventions.

- Develop reliable and valid impact assessment methods that can identify changes in physical activity levels resulting from changes to the physical environment.

Recommendation 2

Who should take action?

Research councils, research commissioners, funders and researchers.

What action should they take?

- Ensure public health outcomes can be identified and attributed as a standard part of research into the links between changes to the physical environment and physical activity levels. Include:
    - control groups or areas
    - appropriate and valid measures, including measures of overall physical activity levels before and after an intervention
    - follow-up periods (ideally, for at least a year)
    - the impact that environmental changes may have outside the target area (such as neighbouring areas)
    - consideration of how interventions can have a different impact on people according to how physically active they were at the outset
    - other factors that may have led to the results.

- Consider the impact of environmental change on health inequalities: how it affects people's physical activity levels according to, for instance, their socioeconomic status, age, gender, disability, ethnicity, religion and sexual orientation.

- Examine the relative contribution of environmental factors and personal characteristics to variations in physical activity levels.

More detail on all the evidence gaps identified during the development of this guidance is provided in appendix D.

6 Updating the recommendations

NICE public health guidance is updated as needed so that recommendations take into account important new information. We check for new evidence 2

and 4 years after publication to decide whether all or part of the guidance should be updated. If important new evidence is published at other times, we may decide to update some recommendations at that time.

7 Related NICE guidance

Published

Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. NICE public health intervention guidance 2 (2006). Available from: www.nice.org.uk/PHI002

Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43 (2006). Available from: www.nice.org.uk/CG043

Under development

Community engagement to improve health. NICE public health guidance (due February 2008)

Workplace health promotion: how to encourage employees to be physically active. NICE public health guidance (due May 2008).

Promoting physical activity, play and sport for pre-school and school-age children in family, pre-school, school and community settings. NICE public health guidance (due January 2009).

8 Glossary

Access/accessibility

'Access' is used to mean that a particular place or destination is accessible to local residents using a mode of transport that involves physical activity. Destinations may include work, healthcare and education facilities and shops.

Active play

The Children's Play Council defines play as: ' …freely chosen, personally directed, intrinsically motivated behaviour that actively engages the child... ' (National Playing Fields Association 2000). Active play involves physical activity. (For a definition of physical activity see below.)

Mobility impairment

Mobility impairment means that an individual has difficulty getting about. This includes disabilities such as visual impairment as well as impairment due to old age and frailty. It also includes temporary problems due to, for instance, transporting young children in buggies or prams.

Opportunity cost

Opportunity cost is a term used in economics to express the notion that money, time or resources spent in one area cannot be spent on something else. The value of an opportunity cost is the value of the next best alternative way of using that time, money or resource.

Physical activity

Physical activity is: ’Any force exerted by skeletal muscle that results in energy expenditure above resting level’ (Caspersen et al. 1985). It includes the full range of human movement and can encompass everything from competitive sport and active hobbies to walking, cycling and the general activities involved in daily living (such as housework).

Physical activity measurements

Physical activity is measured in terms of:

- the time it takes (duration)
- how often it occurs (frequency)
- its intensity (the rate of energy expenditure – or rate at which calories are burnt).

The intensity of an activity is usually measured either in kcals per kg per minute or in METs (metabolic equivalents – multiples of resting metabolic rate). Depending on the intensity, the activity will be described as: moderate-

intensity or vigorous-intensity. Moderate-intensity activities increase the heart and breathing rates but, at the same time, allow someone to have a normal conversation. An example is brisk walking.

Traffic calming

Traffic calming is a means of restricting vehicle speeds, primarily using traffic engineering measures such as speed bumps.

9 References

Caspersen CJ, Powell KE, Christensen G (1985) Physical activity, exercise and physical fitness: definitions and distinctions of health-related research. Public Health Reports 100: 126–131.

Department for Environment, Food and Rural Affairs (2005) Securing the future: delivering the sustainable development strategy. London: The Stationery Office.

Department for Transport (2004) Walking and cycling: an action plan. London: Department for Transport.

Department for Transport (2007a) National travel survey 2006. London: Department for Transport.

Department for Transport (2007b) Manual for streets. London: Department for Transport.

Department of Health (2004) At least five a week: evidence on the impact of physical activity and its relationship to health. London: Department of Health.

Department of Health (2005) Choosing activity: a physical activity action plan. London: Department of Health.

Foster C, Hillsdon M (2004) Changing the environment to promote health enhancing physical activity. Journal of Sports Sciences 22:755–69.

Government Office for Science (2007) Tackling obesities: future choices – project report. London: Foresight.

HM Government (2007a) PSA delivery agreement 12: improve the health and well being of children and young people. London: The Stationery Office.

HM Government (2007b) PSA delivery agreement 18: promote better health and wellbeing for all. London: The Stationery Office.

HM Government (2007c) PSA delivery agreement 21: build more cohesive, empowered and active communities. London: The Stationery Office.

HM Government (2007d) PSA delivery agreement 22: deliver a successful Olympic Games and Paralympic Games with a sustainable legacy and get more children and young people taking part in high quality PE and sport. London: The Stationery Office.

HM Government (2007e) PSA delivery agreement 27: lead the global effort to avoid dangerous climate change. London: The Stationery Office.

Joint Health Surveys Unit (2004) Health survey for England 2004 – updating of trend tables to include 2004 data. London: The Stationery Office.

National Playing Fields Association, PLAYLINK, Children's Play Council (2000) Best play. London: National Playing Fields Association.

Office of the Deputy Prime Minister (2003) Sustainable communities: building for the future. London: Office of the Deputy Prime Minister.

Schmid T, Pratt M, Howze E (1995) Policy as intervention: environmental and policy approaches to the prevention of cardiovascular disease. American Journal of Public Health 85(9): 1207–11.

Sport England (2007) Active design. London: Sport England.

Stamatakis E, Ekelund U, Wareham NJ (2007) Temporal trends in physical activity in England: the health survey for England 1991 to 2004. Preventive

Medicine [in press]. Available from:
http://dx.doi.org/10.1016/j.ypmed.2006.12.014

Appendix A: membership of the Programme Development Group, the NICE Project Team and external contractors

The Programme Development Group

PDG membership is multidisciplinary. It comprises researchers, practitioners, stakeholder representatives and members of the public as follows:

Deirdra Armsby Group Leader, Forward Planning and Transportation, London Borough of Newham

Lorraine Brayford Programme Manager, Sustainable Development, Department of Health Estates and Facilities Division, Leeds

Michael Cahill Community Member

Dr Ric Fordham Senior Lecturer in Health Economics, School of Medicine, Health Policy and Practice, University of East Anglia

Dr Melvyn Hillsdon Senior Lecturer, Department of Exercise and Health Sciences, University of Bristol

Philip Insall Director, Active Travel, Sustrans

Dr Andy Jones Senior Lecturer in Environmental Management, School of Environmental Sciences, University of East Anglia

Professor Roger Mackett Professor of Transport Studies, University College London

Bren McInerney Community Member

Bruce McVean Principal Consultant, Beyond Green

Professor Nanette Mutrie (Chair) Professor of Exercise and Sport Psychology, University of Strathclyde

Dr David Ogilvie Clinical investigator scientist, MRC Epidemiology Unit, Cambridge

Janine Ogilvie Community Member

Professor Ceri Phillips Professor of Health Economics, Swansea University

Liz Prosser Healthy Schools Coordinator, The Learning Trust

Dave Stone Senior Specialist, Health and Wellbeing, Natural England

Tim Stonor Managing Director, Space Syntax Limited.

NICE Project Team

Mike Kelly
CPHE Director

Jane Huntley
Associate Director

Hugo Crombie
Lead Analyst

James Jagroo
Analyst

Nichole Taske
Analyst

Lorraine Taylor
Analyst

Bhash Naidoo
Technical Adviser (Health Economics)

External contractors

External reviewers: effectiveness reviews

‘Physical activity and the environment review one: transport review’ was carried out by the Public Health Collaborating Centre for Physical Activity. (The Centre is an alliance between the British Heart Foundation Health Promotion Research Group [University of Oxford] and the British Heart Foundation National Centre for Physical Activity and Health [Loughborough University].) The principal authors were: Fiona Bull, Nick Cavill, Adrian Davis and Charlie Foster.

‘Physical activity and the environment review two: urban planning and design review’ was carried out by the Public Health Collaborating Centre for Physical Activity. The principal authors were: Fiona Bull, Nick Cavill, Charlie Foster and Catherine Hutton.

‘Physical activity and the environment review three: natural environment review’ was carried out by the Public Health Collaborating Centre for Physical Activity. The principal authors were: Fiona Bull, Kim Buxton, Ruth Carr, Nick Cavill and Charlie Foster.

‘Physical activity and the environment review four: policy review’ was carried out by the Public Health Collaborating Centre for Physical Activity. The principal authors were: Fiona Bull, Nick Cavill and Charlie Foster.

‘Physical activity and the environment review five: building design review’ was carried out by the Public Health Collaborating Centre for Physical Activity. The principal authors were: Fiona Bull, Nick Cavill, Charlie Foster and Catherine Hutton.

External reviewers: expert report

Expert report on ‘Environmental correlates of physical activity and walking in adults and children: a review of reviews’. This was carried out by Adrian Bauman and Fiona Bull working as freelance consultants.

External reviewers: economic appraisal

'A Rapid review of economic literature related to environmental interventions that increase physical activity levels in the general population' was carried out by the York Health Economics Consortium. The principal authors were: Sophie Beale, Matthew Bending, Paul Trueman and Yunni Yi.

'An economic analysis of environmental interventions that promote physical activity' was carried out by the York Health Economics Consortium. The principal authors were: Sophie Beale, Matthew Bending and Paul Trueman.

Fieldwork

The fieldwork was carried out by the Public Health Collaborating Centre for Physical Activity.

Appendix B: summary of the methods used to develop this guidance

The reports of the reviews, expert report and economic appraisal include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the PDG meetings provide further detail about the Group's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available from the NICE website at: www.nice.org.uk/PH008

The guidance development process

The stages of the guidance development process are outlined in the box below:

1. Draft scope
2. Stakeholder meeting
3. Stakeholder comments
4. Final scope and responses published on website
5. Reviews and cost-effectiveness modelling
6. Synopsis report of the evidence (executive summaries and evidence tables) circulated to stakeholders for comment
7. Comments and additional material submitted by stakeholders
8. Review of additional material submitted by stakeholders (screened against inclusion criteria used in reviews)
9. Synopsis, full reviews, supplementary reviews and economic modelling submitted to the PDG
10. The PDG produces draft recommendations
11. Draft recommendations published on website for comment by stakeholders and for field testing
12. The PDG amends recommendations
13. Responses to comments published on website
14. Final guidance published on website

Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and facilitated the development of recommendations by the PDG. The overarching question was:

What environmental interventions are likely to increase physical activity levels in the general population by:

- incorporating physical activity into every day life
- increasing formal or informal recreational activity (including active play)
- increasing active travel?

The subsidiary questions were:

1. What is the aim/objective of the intervention?
2. How does the content influence effectiveness?
3. How does delivery influence effectiveness?
4. Does the site/setting influence effectiveness?
5. Does the intensity (or length) of the intervention influence effectiveness/duration of effect?
6. Does impact vary according to the age, sex, socio-economic position and ethnicity of the target population?
7. How much does it cost (in terms of money, people and time)?
8. What evidence is there on cost effectiveness?
9. What are the barriers to implementation?
10. What is the differential impact on inequalities in health?
11. What are the adverse or unintended consequences?

These questions were refined further in relation to the topic of each review (see reviews for further details).

Reviewing the evidence of effectiveness

Five reviews of effectiveness were conducted. A review of review-level correlate studies was also carried out.

Identifying the evidence

The following databases were searched for all five effectiveness reviews, for interventions involving a change to the environment and which reported physical activity outcomes (from January 1990–July 2006):

- Cambridge Scientific Abstracts (CSA)
- Cambridge Scientific Abstracts Education Resources Information Centre (CSA ERIC)
- CINAHL
- Cochrane Library
- EMBASE
- Global Health
- ISI Science Citation Index and Social Science Citation Index
- MEDLINE
- Public Affairs Information Services (PAIS)
- Psychlit
- PsycINFO
- SIGLE
- SportDISCUS.

Other relevant databases were also searched for each review and references from included studies were searched. In addition, a number of websites were searched and information was sought from experts.

Expert report

The review of correlates identified reviews published between 2002–2007 that reported on factors in the built or natural environment that were linked to physical activity or walking.

Further details of the databases, websites, search terms and strategies are included in the full reports.

Selection criteria

Studies were included in the effectiveness reviews if:

- an intervention altered the physical environment
- physical activity levels were measured at least after the intervention had taken place
- (for the policy review) environmental change was linked to a policy initiative.

Studies were excluded if they:

- did not report on an environmental intervention
- did not include physical activity as an outcome
- were purely descriptive or an opinion piece
- were not published in English
- were published before 1990.

Papers were included in the expert report (correlates review) if they:

- were reviews
- used a clear measure of physical activity or walking
- provided evidence of a review or summary process
- were published in English
- were published between 2002–2007.

Papers were excluded if they:

- focused on strength training or clinical exercise programmes (such as exercise for rehabilitation)
- only reported the results from one study
- focused on one disease or a specific clinical condition.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for development of NICE public health guidance' (see appendix E). Each study was described by study type and graded (++, +, -) to reflect the risk of potential bias arising from its design and execution.

Study type

- Meta-analyses, systematic reviews of randomised controlled trials (RCTs) or RCTs (including cluster RCTs).

- Systematic reviews of, or individual, non-randomised controlled trials, case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies, correlation studies.

- Non-analytical studies (for example, case reports, case series).

- Expert opinion, formal consensus.

Study quality

++ All or most of the criteria have been fulfilled. Where they have not been fulfilled the conclusions are thought very unlikely to alter.

+ Some criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions.

- Few or no criteria fulfilled. The conclusions of the study are thought likely or very likely to alter.

The studies were also assessed for their applicability to the UK.

Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full reviews and the synopsis).

The findings from the studies were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements reflect the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.

Economic appraisal

The economic appraisal consisted of a review of economic evaluations and a cost-effectiveness analysis.

Review of economic evaluations

In addition to scanning the effectiveness evidence for economic data, the following databases were searched:

- EconLIT
- Health Economic Evaluation Database (HEED)
- Health Management Information Consortium (HMIC)
- NHS Economic Evaluation Database (NHS EED).

Searches were also undertaken of PDG members' personal libraries and the Internet. Details can be found in the full review (www.nice.org.uk/PH008).

Studies were reviewed if they provided economic evidence directly linked to any of the environmental interventions considered in the effectiveness reviews. Published studies that met the inclusion criteria were rated to determine the strength of the evidence, using the NICE algorithm and the Drummond checklist (Drummond MF, Jefferson TO [1996] 'Guidelines for authors and peer reviewers of economic submissions to the BMJ'. British Medical Journal 313: 2075–283).

Cost-effectiveness analysis

Three economic models were constructed to incorporate data from the effectiveness and cost-effectiveness reviews. The results are reported in: 'An economic analysis of environmental interventions that promote physical activity'. It is available on the NICE website at: www.nice.org.uk/PH008

Fieldwork

Fieldwork was carried out to evaluate the relevance and usefulness of NICE guidance for practitioners and the feasibility of implementation. It was conducted with professionals who are involved in architecture, transport, environment, planning and public health.

The fieldwork comprised:

- eight focus groups conducted in London, Manchester, Bristol and York by the Public Health Collaborating Centre for Physical Activity with members of the groups listed above
- three one-to-one interviews: with a senior Highways Agency official and two architects.

The studies were commissioned to ensure there was ample geographical coverage. The main issues arising from these studies are set out in appendix C under 'Fieldwork findings'. The full fieldwork report is available on the NICE website: www.nice.org.uk/PH008

How the PDG formulated the recommendations

At its meeting in May 2007, the PDG considered the evidence of effectiveness and cost effectiveness and the expert report to determine:

- whether there was sufficient evidence (in terms of quantity, quality and applicability) to form a judgement
- whether, on balance, the evidence demonstrates that the intervention is effective or ineffective, or whether it is equivocal
- where there is an effect, the typical size of effect.

The PDG developed draft recommendations through informal consensus, based on the following criteria:

- Strength (quality and quantity) of evidence of effectiveness and its applicability to the populations/settings referred to in the scope.
- Effect size and potential impact on population health and/or reducing inequalities in health.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of risks and benefits.
- Ease of implementation and the anticipated extent of change in practice that would be required.

The PDG also considered whether a recommendation should only be implemented as part of a research programme where evidence was lacking.

Where possible, recommendations were linked to an evidence statement(s) (see appendix C for details). Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

The draft guidance, including the recommendations, was released for consultation in June 2007. At its meeting in September 2007, the PDG considered comments from stakeholders and the results from fieldwork. The guidance was signed off by the NICE Guidance Executive in November 2007.

Appendix C: the evidence

This appendix sets out the evidence statements taken from five reviews (see appendix B for the key to study types and quality assessments) and links to the relevant recommendations. The evidence statements are presented here without references – these can be found in the full review (see appendix E for details). It also sets out a brief summary of findings from the expert report and the economic appraisal.

The five reviews of effectiveness are:

- 'Physical activity and the environment review one: transport review'
- 'Physical activity and the environment review two: urban planning and design review'
- 'Physical activity and the environment review three: natural environment review'
- 'Physical activity and the environment review four: policy review'
- 'Physical activity and the environment review five: building design review'.

Evidence statement **T1** indicates that the linked statement is numbered **1** in 'Physical activity and the environment review one: transport'. Evidence statement **UP1** indicates that the linked statement is numbered **1** in 'Physical activity and the environment review two: urban planning and design'. Evidence statement **NE2** indicates that the linked statement is numbered **2** in 'Physical activity and the environment review three: natural environment review'. Evidence statement **P1** indicates that the linked statement is numbered **1** in 'Physical activity and the environment review four: policy review'. Evidence statement **BD3** indicates that the linked statement is numbered **3** in 'Physical activity and the environment review five: building design review'.

The reviews and economic appraisal are available on the NICE website (www.nice.org.uk/PH008). Where a recommendation is not directly taken from

the evidence statements, but is inferred from the evidence, this is indicated by IDE (inference derived from the evidence) below.

Recommendation 1: evidence statements UP2, UP5, P1, P2, P3; expert report; IDE

Recommendation 2: evidence statements T1, T2, T3, T4, T5, T6, UP3, P2; expert report; IDE

Recommendation 3: evidence statements T5, UP1, P3; expert report; IDE

Recommendation 4: evidence statements UP4, UP5, UP6, NE1, NE2; expert report; IDE

Recommendation 5: evidence statements T5, UP5, BD1; IDE

Recommendation 6: evidence statement BD2

Recommendation 7: evidence statement BD3

Evidence statements

Evidence statement T1

The evidence from five studies: one 2 (++), two 2 (-) , one 3 (+) and one 3 (-) quality, tends to suggest that traffic calming can lead to small self-reported and observed increases in walking and cycling (including children's play) both in the short and in the long term. However, three studies: one 2 (+), two 2 (-) reported either no significant change in self-reported and observed levels of walking or cycling, or slight declines in walking and cycling in the short and long term. The evidence is applicable to the UK.

The evidence from one 2 (++), two 2 (-) and one 3 (+) quality studies suggests that traffic-calming interventions may be useful in enabling children specifically to benefit from physical activity through play outdoors in the short and long term.

Evidence statement T2

Evidence from three studies one 2 (++) and two 2 (+) quality, suggests that introduction of multi-use trails can lead to increases in levels of walking and cycling in both the short and long term. However, one US 2 (++) quality study found decreases in walking and cycling following the introduction of a multi-use trail.

The evidence from the UK studies is applicable to the UK while the evidence from the US and [other] Australian studies may not be directly applicable.

There is some evidence to suggest that the setting of the delivery of the intervention may influence its effectiveness in the short term and long term. Specifically, trails located closer to population centres may be better used.

Evidence statement T3

There is evidence from three 2 (-) quality studies to suggest that closing or reducing the capacity of roads can lead to long-term increases in levels of walking within the area of the scheme. One 2 (-) quality study suggests that closing or reducing the capacity of roads can lead to increases in cycling.

Evidence from three 2 (-) quality studies would suggest that it is important that a wider range of measures is introduced to support road closures.

There is some evidence to suggest that the setting of the delivery of the intervention through location in city or town centres can lead to short-term increases in cycling and long-term increases in walking.

There is evidence from two 2 (-) quality studies that closing or restricting use of roads can result in a decrease in road traffic casualties.

There is some evidence to suggest that more intense interventions can lead to long-term increases in walking and cycling. This evidence is likely to be applicable in the UK, with appropriate adaptations.

Evidence statement T4

There is evidence from one 2 (++) and one 2 (-) quality study to suggest that introduction of road user charging schemes and changes to the road system can lead to short-term increases in levels of walking and long-term increases in cycling within the area of the scheme.

There was evidence of either no change or a decrease in road traffic casualties as a result of the road user charging interventions. The evidence comes from UK studies and so is directly applicable.

Evidence statement T5

Evidence from one 2 (+), three 2 (-), one 3 (++), and two 3 (-) quality studies suggests that the introduction of cycle infrastructure can lead to long-term increases in levels of cycling within the area of the scheme.

Cycle infrastructure interventions may result in important positive public health outcomes alongside increasing cycling, notably a reduction in cycle casualties.

It appears that cycle infrastructure in both urban and rural areas can be effective in increasing cycling. It is likely that this evidence is applicable to the UK, with appropriate modification for existing infrastructure and cultural issues.

Evidence statement T6

There is evidence from one 2 (+) and one 3 (+) quality study to suggest that introduction of safe routes to schools schemes can lead to short-term increases in levels of walking and cycling within the area of the scheme. This evidence may be applicable to the UK with some caution.

Evidence statement UP1

The evidence from four studies: three 2 (-) quality and one 3 (-) quality, tends to suggest that interventions to change the urban structure at the street level can lead to increased levels of pedestrian activity in the short term. The evidence from two studies: one 3 (-) quality and one 2 (-) quality, tends to

suggest that interventions changing the urban structure at the street level can lead to increased levels of children out in the areas in the long term.

However, the evidence from two 2 (-) quality studies reported no changes in various measures of activity in the short term in either children or adults, and one 2 (-) quality study reported decreased pedestrian flow in the short term.

From this diverse body of evidence it is difficult to interpret any clear trends in how the content of the intervention may have influenced effectiveness. It does appear however that in most cases, a multi-faceted approach was taken to re-designing the urban environment giving priority to the needs of pedestrians.

There is some indication that urban change interventions may have a differential affect on different sub-population groups, however, there is insufficient evidence to assess this issue in any detail.

Overall, the evidence tends to suggest that other outcomes such as perception of safety, and fear of crime and perception of attractiveness, pollution (air and noise) can be favourably changed as a result of street-level urban change interventions.

Evidence statement UP2

The evidence from one 2 (+) quality quasi-experimental study suggests that the composition of the built environment at the community level may have a positive impact upon levels of walking and cycling.

Evidence statement UP3

The evidence from two 3 (+) quality studies tends to suggest that trails can lead to self-reported increases in physical activity in the short term and long term. Overall, based on two 3 (+) studies, the evidence tends to suggest that trail surface, length and maintenance influence trail use and attitudes towards trails.

On the basis of two 3 (+) quality post-only studies, there is insufficient evidence to assess any differential effect of the interventions by socio-demographic or cultural factors.

Overall, there is some evidence from two 3 (+) studies that trails can be perceived as safe places to use for physical activity, specifically walking.

Evidence statement UP4

Overall, based on one 2 (+) quality controlled before and after study the evidence suggests that modification and promotion of parks may increase walking and can raise the awareness of parks.

Evidence statement UP5

The evidence from one 3 (-) quality, post-only study suggests that building shopping malls at the fringes of cities may lead to a reduction in the number of shopping trips made per month, and a tendency for increased use of motorised vehicles and decreased pedestrian travel as the mode to access the shopping mall.

Evidence statement UP6

Overall, the evidence from one 3 (-) quality, post-only study suggests that building a boardwalk along a foreshore may increase levels of self-reported physical activity, particularly in people [who were] previously active.

Evidence statement NE 1

There is insufficient evidence to draw any conclusions on the effect of interventions involving changes to the physical environment and design features of woodland areas on physical activity outcomes. There is, however, evidence from one 3 (-) quality, post-only study to suggest that building creative features along a woodland trail may increase visitor numbers.

Evidence Statement NE2

There is insufficient evidence to draw any conclusions on the effect of interventions involving changes to the physical environment and design features of coastal areas on physical activity outcomes. There is, however, evidence from one 3 (-) quality, post-only study to suggest that improving a coastal path may increase frequency and duration of visits.

Evidence statement P1

The evidence from one 3 (-) study suggests there may be an association between national policies on physical activity which include a focus on improving the environment, and increased recreational physical activity and sport.

Evidence statement P2

The evidence from one 3 (-) study suggests there may be an association between national transport-related policies that include an environmental modification component and improved levels of walking and cycling compared to countries without such policies.

Evidence statement P3

The evidence from one 3 (-) study suggests there may be an association between national spatial planning policies and levels of walking and cycling, particularly in more urbanised areas.

Evidence statement BD1

The evidence from three studies: one 1 (+), one 2 (+) quality, and one 2 (-) quality, suggests that interventions that include changes to the built environment of a worksite may lead to both short and long-term changes in levels of physical activity

From this set of studies, conducted in diverse settings and involving different worksites and different interventions, it is difficult to interpret any clear trends on how the content of the intervention may have influenced effectiveness. It does appear, however, that the provision of facilities or trails for walking, jogging or cycling, and improvements to existing or provision of new facilities (such as new space, improved equipment, or improved aesthetics [painting, carpet]) may lead to increases in use and/or levels of physical activity.

Evidence statement BD2

The evidence from two 2 (+) quality studies aimed at improving the physical environment of a stairwell by physical improvements such as carpets, painting

and addition of art work may lead to increases in stairwell usage in the short term.

Evidence statement BD3

The evidence from three studies: one 1 (++) RCT and two 2 (++) controlled before and after studies suggests that colourful/fluorescent markings painted on a school playground can lead to objectively assessed increases in variables related to physical activity during playtime, such as time spent in moderate/vigorous physical activity, time spent in vigorous activity and total energy expenditure during play, in the short term. However, there is no evidence available to assess the effect of school playground markings on physical activity beyond 4 weeks post implementation.

Expert report: 'Environmental correlates of physical activity and walking in adults and children: a review of reviews' (Bauman and Bull 2007)

- Environments and physical activity
  There are reasonably consistent associations between physical activity levels and the accessibility of physical activity and other facilities, the density of residential areas, land use mix and urban 'walkability' scores. There are also reasonably consistent links between physical activity levels and the perceived safety of an area and the availability of footpaths or equipment for exercising. There were less clear links between physical activity levels and the aesthetic features of the environment, topographic factors and perceived levels of crime.

- Environments and walking
  The correlates for walking are more similar than different to those found for general physical activity, although there are some differences between walking for exercise and walking to reach a destination.

Cost-effectiveness evidence

Overall, the walking and cycling infrastructure, stair signage and painted school playgrounds were all considered cost effective (although this was based on the limited effectiveness evidence available).

Interventions involving the walking and cycling infrastructure could help people to avoid long-term chronic diseases, leading to incremental cost-effectiveness ratios (ICERs) of approximately £130– £25,000 per quality of life year (QALY). When additional, short-term improvements in wellbeing are taken into account, ICER estimates range from £90– £9400.

A cost–benefit analysis (CBA) of the cycling infrastructure generated a standardised cost–benefit ratio of 1:11 which, from a transport perspective, is very cost effective.

Lack of data meant that a number of assumptions had to be made, particularly when translating proxy measures for physical activity (for example, the number of cyclists or walkers) into the physical activity intensity levels required to benefit health over the short and longer term. However, sensitivity analyses demonstrated that the assumptions and estimates would not markedly affect the ICER per QALY estimates generated in the main report.

Where physical activity was not the main aim (for example, where an intervention aimed to reduce traffic accidents or congestion) the physical activity benefits could be considered to be free. However, it may be argued that once these benefits are identified and included in a cost–benefit analysis, their contributing costs need to be taken into account. Promoting physical activity through these types of intervention is likely to incur only a small, additional cost.

Fieldwork findings

Fieldwork aimed to test the relevance, usefulness and the feasibility of implementing the recommendations and the findings were considered by the PDG in developing the final recommendations. For details, go to the fieldwork section in appendix B and visit the NICE website at: www.nice.org.uk/PH008

Fieldwork participants were very positive about the recommendations and their potential to help promote physical activity. Although many said they were overwhelmed with guidance on how to do their jobs, they welcomed this endorsement and recognition from the health sector of the links between

physical activity and the environment They thought it was highly appropriate that NICE should issue such guidance and believed that the Institute's reputation and authority would maximise the impact of the recommendations.

There was a very strong feeling among participants that many of the recommendations appeared to re-state existing policy or legislation, but were not explicitly linked to existing policy documents. They suggested that NICE would have a greater impact if it worked to influence policy and connected its work to existing and new policy and legislation.

Appendix D: gaps in the evidence

The PDG identified a number of gaps in the evidence related to the programme under examination, based on an assessment of the evidence. These gaps are set out below.

1. There is a lack of good quality studies which identify changes in an individual's overall physical activity levels (taking all their activities into account) using valid pre and post-intervention measures.

2. There is a lack of evidence on the broader geographical impact of interventions (including unintended impacts, either positive or negative). This is particularly important for transport interventions.

3. There is a lack of evidence on how environmental interventions affect physical activity levels in rural settings. There is also a lack of evidence on the effect of environmental interventions specific to rural areas.

4. There is little evidence on the differential impact that interventions can have on different social groups. This includes people of different ages, sex, ethnicity, religion, disability and sexual orientation.

5. There is a lack of evidence on how environmental interventions can impact on physical activity levels in the UK.

6. There is a lack of evidence on the long-term effect of interventions to change behaviour.

7. Appropriate methodologies and assessment tools are needed to measure how environmental policies and projects can help increase people's physical activity levels, thereby improving their health.

8. There is a lack of good quality evidence on the impact of changes made to the natural environment.

9. There is a lack of good quality evidence on how environmental changes within schools (such as the introduction of bike sheds) can

affect pupils' physical activity levels. The only good quality evidence relates to changes made to primary school playgrounds.

10. There is a lack of evidence on how environmental changes in the workplace (other than modifications to stairwells) can affect employees' physical activity levels. Other changes that could be evaluated include the introduction of travel-related facilities, such as secure bicycle parking and showers, or modifications to the layout of the workplace to encourage more physical activity during the day.

11. There is a lack of evidence on the cost-effectiveness of interventions involving environmental change. In addition, the economic studies that are available use different methods, making comparisons difficult.

The Group made two recommendations for research. These are listed in section 5.

Appendix E: supporting documents

Supporting documents are available from the NICE website (www.nice.org.uk/PH008). These include the following.

- Reviews of effectiveness:
  - 'Physical activity and the environment review one: transport review'
  - 'Physical activity and the environment review two: urban planning and design review'
  - 'Physical activity and the environment review three: natural environment review'
  - 'Physical activity and the environment review four: policy review'
  - 'Physical activity and the environment review five: building design review'.

- Expert report:
  - 'Environmental correlates of physical activity and walking in adults and children: a review of reviews'.

- Economic analysis:
  - 'A Rapid review of economic literature related to environmental interventions that increase physical activity levels in the general population'
  - 'An economic analysis of environmental interventions that promote physical activity'.

- Equality impact assessment:
  - 'Physical activity and environment guidance – equality impact'.

- A quick reference guide (QRG) for professionals whose remit includes public health and for interested members of the public. This is also

available from the NHS Response Line (0870 1555 455 – quote reference number N1444).

For information on how NICE public health guidance is developed, see:

- 'Methods for development of NICE public health guidance' available from: www.nice.org.uk/phmethods
- 'The public health guidance development process: an overview for stakeholders including public health practitioners, policy makers and the public' available from: www.nice.org.uk/phprocess

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Briefing for the Health and Wellbeing Scrutiny Inquiry 15 December

Purpose: Update on progress made in relation to 'Can't Wait, Leeds Childhood Obesity Strategy'.

Janice Burberry –Children's Lead, Public Health Directorate NHS Leeds

In Leeds, 1,389 or one in five children in Reception has a weight above what is considered to be healthy. This figure is very slightly below regional and national averages. However 2,505, or almost one in three, children in Year 6 are either overweight or obese which is slightly above regional and national averages. In Leeds this appears to be a rising trend. Levels of obesity for both Reception and Year 6 children are higher in deprived areas of the city.

As a result of the growing childhood obesity nationally, the Government has set a target to reduce the proportion of overweight and obese children to the year 2000 levels by 2020.

'Can't Wait – Leeds Childhood Obesity Strategy 2006-16' provides information on prevalence, causes and local action needed to help Leeds families to be a healthy weight.

Partnership working – currently there is no city wide partnership group which focuses on implementing the strategy. A proposal to establish strategic board to champion and support partners to tackle child and adult obesity is currently being shared with key stakeholders.

Significant progress has been made in relation to Can't Wait.

Maternal Obesity

A care pathway is being developed to help mothers to retain a healthy weight during their child bearing years. Specialist weight management services have been piloted at Children Centres and targeted treatment support developed.

Breast feeding

Leeds Breast Feeding Strategy has been written and will be launched January 2010. A successful bid was made for £100k to pilot breast feeding support service and to work with young mums to promote the benefits of breast feeding. We are on target to achieve UNICEF Baby Friendly Initiative (BFI) accreditation. This measure the extent to which the local health family are compliant with evidence based best practice to support families to breast feed.

HENRY (Health Exercise and Nutrition in the Really Young)

Leeds have trail blazed this nationally recognised and very well received intervention in local children's centres.12 centres have taken part in the training with 190 children's centre staff and 10 members of the attached health visiting team participating. Eight staff have

completed the Group Facilitation Training and are now running parents groups. 4 local trainers achieved accreditation and are now able to train independently of the national team. EYS have seconded Children's Centres Manger to support roll out of training and coordinate Lets Get Healthy with Henry groups. Feedback from staff and parents has been extremely positive, with both describing lifestyle changes they have made as a result of being part of the initiative. Work in the city is being evaluated as part of a national independent evaluation.

Change4life

NHS Leeds is commissioning services in each of the demonstration sites (Harehills and Middleton) to support local families to achieve C4Life goals. 2010 will see the launch of C4Life Be Healthy Challenge;this will work with schools to engage, support and reward families to make a positive C4Life behaviour change . The learning from a Change 4life child led fun day in Middleton is being used to develop a toolkit to support schools and other front line staff to make maximum use of the campaign. The Leeds C4L group has continued to meet to promote and champion the use of the research and branding across the city . The national campaign will focus on adult obesity in the New Year.

Physical Activity

Education Leeds and partners have achieved PEESCL and LHSS targets ahead of national timescales In line with the local LPSA strategy targets. LCC Swim4Life has been established and has been successful in engaging under 16s in free swimming sessions across the city. NHS Leeds Engaging Inactive Children Programme has been re branded Active4life.and expanded to include areas in the East and west of the city. The programme which includes DAZL dance, Leeds United Football, The Works BMX and Skate Parks and Active Clubs programme is on target to engage 8000 of our least active children living in areas of deprived Leeds. Consultation work with children and young people has shown high levels of interest in free sports (BMX, skate boarding & free running) Support provided to Works Skate Park enabled them to offer free entry during summer holidays, attracting 350 young people per day. An event is planned for February 2010 to raise awareness of this interest and to consider how Leeds children and young people can be supported to make full use of Leeds freesport facilities. Leeds School Partnership Development Managers have been awarded £8k from the national Bikability Programme to promote cycling proficiency. Through innovative partnership working young people, accessing this scheme, will also be able to attend free staffed sessions at the Works Skate Park and Leeds BMX tracks to develop a passion for cycling alongside their proficiency skills.

Planning for health

The critical role of the broader environment on health is being increasingly recognised. Promising case studies are providing useful pointers; where better use of existing planning regulations and regeneration opportunities have been used to increase every day activity levels and increase access to healthy competively priced food. The public sector's leadership role in providing access to healthy affordable food within buildings, whether places of

employment or leisure is also being recognised . A Leeds' event is planned for February which aims to raise awareness of the potential of this work and will showcase local examples of good practice.

Treatment services

Watch It Weight Management Service, following its re-launch in April, has been commissioned to run 8 clinics, focused in 10% most deprived SOAs, for families with children aged 8-17 years. To date these clinics have engaged 61 families, with a further set of recruitment sessions planned for January. Carnegie Weight Management is currently providing a community weight management clinic in Middleton. The clinic planned for Harehills was postponed due to low numbers, but will be offered again from January. Research funding is being used to develop and pilot a model of working with parents of children 5 to 8 years. To date 15 families have expressed an interest in attending the 10 week pilot at Chapel Town Children's Centre.

Over the last 2 years we have delivered a wide range of interventions to prevent childhood obesity and provide support to children and families who are overweight or obese . To stem the predicted increase and the huge management and personal costs of this condition we now need to make Leeds an environment where it is easier to be a healthy weight than obese and find ways to scale up and sustain our interventions .

We need champions who will

- increase awareness of the importance of the environment, on children and families achieving a healthy weight, and promote change.
- identify opportunities within current provision to do things differently .
- challenge when the health impact of developments has not been sufficiently prioritised.

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Obesity Scrutiny Report- 15 December 2009
Adult obesity – NHS Leeds
Prepared by Emma Croft, Obesity, Food and Physical Activity- NHS Leeds

Prevalence in Leeds
The scale of the problem in Leeds is difficult to quantify with great accuracy, especially for adults . The QOF recording BMI in GP practice as well as the data being collected from school children through the National Child Measurement Programme will give a more accurate indication in the future, although existing data appears to be in line with regional estimates.
Estimates are currently based on Health Survey for England 2003 data with the estimated prevalence for obesity in Leeds being 23.8% in women and 22.7% of men. Based on this prevalence data we can conservatively estimate that for the population Leeds approximately 154,000 people would be expected to be obese (BMI of 30kg/m^2 or more). This figure is not weighted for deprivation but it should be noted men and women from unskilled manual groups are 4 times more likely to be obese than professional groups. Significant additional numbers are overweight.
The Yorkshire and Humber region has the highest prevalence of obese men and young men. Obesity in women (at 23.8%) is higher than the England average and the second highest across all regions. According to the recent Foresight report, the region has the highest predicted growth rate of obesity prevalence, if current trends continue, it is predicted that 36% of men and 28% of women will be obese by 2015 (Foresight 2007) with 70% of the population obese by 2050, which would make Yorkshire and Humber the fattest region in the country.

Costs
Estimated costs to the NHS in Leeds of diseases related to overweight and obesity were 197.4 million in 2007 and predicted to be 204.9 million by 2010 (Healthy weight, Healthy Lives toolkit 2008). National costs by 2050 are predicted to be 6.5.billion and pose the single biggest threat to the NHS. Obesity is the second most important preventable cause of ill health and death after smoking.

National Direction / Approach
The National strategy "Healthy Weight, Healthy Lives, HMSO 2008" aims:
"To reverse the rising tide of obesity and overweight in the population by ensuring that all individuals are able to maintain and healthy weight. Our initial focus is on children: by 2020 we will have reduced the proportions of overweight and obese children to 2000 levels."
Although initial focus of the strategy is children; however there are there are key challenges to tackle adult obesity.

Contribution of NHS Leeds
NHS Leeds is tasked with delivering Healthy Ambitions Staying Healthy in Yorkshire and Humber Pathway. Staying Healthy has 5 recommendations directly relating to obesity. Delivering on these pathways is a priority for NHS Leeds. An update on progress against each recommendation related to obesity is provided below:

Progress against Healthy Ambitions recommendation 6 & 7
Every PCT should commission localised weight management services for their local population including obesity surgery. To meet life expectancy targets these should focus on adults at mid life following a smoking cessation model of implementation.

Local weight management services are commissioned from Leeds Community Care Trust. The service provides tier 1 and 2 services as well as assessment for tier 3 specialist obesity surgery services. Level 1 consists of a structured multifaceted weight management programme with ongoing physical activity opportunities delivered in partnership with both leisure services and VCFS organisations in local venues. Services are currently available to people registered in 38 of the 42 targeted GP practices in deprived Leeds and 21 in the previous North West PCT area (where the service was originally established). Self referral to group programmes is available.

Take up of services is consistent with that of smoking cessation services. Weight loss results are comparable to equivalent interventions in other parts of the Region.

Tier 2 services are weight management clinics targeting high risk individuals (higher BMI's, complex co-morbidities, using prescribed anti obesity medications to little effect). This offers tailored advice, and more intensive motivational interviewing, cognitive behavioural therapy and solution based approaches to behaviour change. This also is the level providing bariatric surgery assessment and work up for those meeting regionally agreed criteria.

NHS Leeds and LTHT have contributed heavily to the Regional Specialist Commissioning Group work to develop a commissioning policy and designation process for obesity surgery across the Region. The pathway, triage model and referral proforma adopted regionally are based on service development work undertaken between NHS Leeds and LTHT.

An assessment and triage system is in place through the community weight management service, which is working to restricted criteria B as defined by SCG. (B= BMI 50 or 45 with co-morbidities). Patients are able to choose from a range of designated providers including LTHT, Spire, Bradford, and York.

Progress against Healthy Ambitions recommendation 8: *NICE guidance on brief interventions should be implemented consistently by a wide range of staff; ideally this would include primary and secondary care staff, community services, locally authority and voluntary settings.*

NHS Leeds is committed to a delivering a healthy living services project which aims to implement a whole system approach to brief interventions in primary care, followed by systematic referral and signposting to healthy living services and opportunities. This will include interventions around smoking, weight management, alcohol and physical activity. The initial focus will be individuals identified through NHS Health Check performed in the 42 target practices in the most deprived wards in Leeds.

Progress against Healthy Ambitions recommendation 10: There *should be a systematic programme of local work to reduce levels of obesity through the development of:*

- ***Food policy and better food skills for adults***
- ***Transport and the built environment making activity easier and safer***
- ***More opportunities for active leisure***

Leeds has a city wide food strategy "Leeds Food Matters" which includes actions around increasing access to programmes which support the development of food skills. NHS Leeds commissions 56 cooking skills courses from VCFS. Planned work for 2010 is the development of a Ministry of Food "Food centre" and health point in Kirkgate Market and the promotion of the "Cook 4 life" aspect of the change 4 life campaign.

Transport and health are both signed up to the delivery of "Active Leeds a Healthy City".

There is a workshop planned for February 2010 to look at closer working between health and planning. This is an area which has the potential to make the biggest impact on reducing the rate of increase in obesity and increase the effectiveness of weight management "treatments" by developing an environment conducive to being a healthy weight. This is the least developed area concerning tackling obesity and needs considerable strengthening.

NHS Leeds and Leeds City Council are jointly committed to Active Leeds and the strategic priority to increase activity for all. Please see report from Leeds Leisure Services. Beyond leisure services, the PCT commissions a number of activity opportunities from local agencies. For example Leeds has an active network of walking programmes being delivered targeting at risk populations.

Conclusion

Good progress is being made to address obesity and provide interventions to those struggling with overweight and obesity. However there needs to be considerable strengthening and focus of action to address how the environment in Leeds supports achieving and maintaining a healthy weight. This is required to reduce the rate of increase in obesity and to enable treatment interventions to be effective in the long term.

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House of Commons
Health Committee

Obesity

Third Report of Session 2003–04

Volume I

Report, together with formal minutes

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Committee staff

The current staff of the Committee are Dr J S Benger (Clerk), Keith Neary (Second Clerk), Laura Hilder (Committee Specialist), Frank McShane (Committee Assistant) and Anne Browning (Secretary).

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. Written evidence is cited by reference to Volume II of this Report, in the form 'Ev' followed by the page number, and by reference to Appendix numbers for written evidence contained in Volume III.

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Report

Summary

Introduction

Around two-thirds of the population of England are overweight or obese. Obesity has grown by almost 400% in the last 25 years and on present trends will soon surpass smoking as the greatest cause of premature loss of life. It will entail levels of sickness that will put enormous strains on the health service. On some predictions, today's generation of children will be the first for over a century for whom life-expectancy falls.

Obesity is associated with many health problems including coronary heart disease, diabetes, kidney failure, osteoarthritis, back pain and psychological damage. The strong association between obesity and cancer has only recently come to light.

We estimate the economic costs of obesity conservatively at £3.3–3.7 billion per year and of obesity plus overweight at £6.6–7.4 billion.

Causes

Determining the causes of obesity is central to tackling it. The exact extent of the relative responsibility of diet and activity remains unclear and it is crucial that both sides of the 'energy equation' are addressed.

At its simplest level, obesity is caused when people overeat in relation to their energy needs. At the same time as energy expenditure has dropped considerably, environmental factors have combined to make it increasingly easy for people to consume more calories than they need. Energy-dense foods, which are highly calorific without being correspondingly filling, are becoming increasingly available. And while our evidence suggested that people are, generally speaking, aware of what constitutes a healthy diet, there are multiple barriers to their putting this into practice. In the absence of practical cookery lessons, children and young people are growing up without the skills to prepare healthy meals, compounding reliance on convenience foods, which are often high in energy density; healthy-eating messages are drowned out by the large proportion of advertising given over to highly energy-dense foods; other types of food promotion, as well as pricing also make buying unhealthy food more attractive and economical than healthy alternatives; and food labelling, a key tool to help consumers choose healthy foods, is frequently either confusing or absent.

Turning to the role of physical inactivity, only just over a third of men and around a quarter of women achieve the Department of Health's target of 30 minutes of physical activity 5 times a week. Levels of walking and cycling have fallen drastically in recent decades, while the number of cars has doubled in 30 years. Children are also increasingly sedentary both in and out of school. A fifth of boys and girls undertake less than 30 minutes activity a day. Television viewing has doubled since the 1960s, while physical activity is being squeezed out of daily life by the relentless march of automation.

Solutions

Solutions to the problem of obesity need to be multifaceted, recognising the true complexity of the issue, must address environmental as well as individual factors, and should be designed to bring about long-term, sustainable change, rather than promising overnight results. Obesity is also an issue which demands truly joined-up policy-making, and to ensure this we have recommended the appointment of a specific public health Cabinet committee, chaired by the Secretary of State for Health, to oversee the development of Public Service Agreement targets relating to obesity across all relevant government departments.

It is vital to ensure that the public are fully aware of the dangers of obesity and the importance of healthy eating, and that they also have the practical skills and information they need to implement these messages in their daily lives. To this end we have recommended a sustained public education campaign, improved practical food education for children and young people and, crucially, legislation to promote a simple food classification and labelling system which makes choosing healthy foods easy.

The promotional efforts of the food industry are frequently directed towards children. While we recognise that it is entirely appropriate for parents to retain control over their children's diet, we were shocked to find evidence that in its campaign for Walkers Wotsits, Abbot Mead Vickers advertising agency deliberately aimed to undermine parental control by exploiting 'pester power', despite this practice contravening the Advertising Standards Authority code of practice. We have recommended tighter controls on the advertising and promotion of foods to children, though we favour a voluntary approach in the first instance. We have also recommended that children's nutrition in school be improved, both through a move away from the promotion of high-energy density foods within schools, and through the introduction of better standards for school meals.

The Government has recently undertaken work with industry to reduce salt levels in foods, and we have recommended that work should be undertaken to reduce overall energy-density levels. We have also recommended that industry should undertake healthy pricing schemes, to make healthy foods a realistic choice for consumers who are buying food on a budget. Underpinning this, we believe that agricultural policies should also be reformed to take account of the public health agenda

Solutions to the problems of physical activity will demand a cohesive approach across many Government departments. We commend the funding and commitment now being devoted to organised recreation both in schools and in wider society though we note that fewer than half of school children are meeting the target of 2 hours of physical activity per week. This target itself we regard as inadequate and recommend instead a target of 3 hours physical activity a week for children. In order to involve those children traditionally 'turned off' sport we recommend that imaginative ways are found to broaden the physical activity agenda to include areas such as dance or aerobics. We also recommend that schools have in place effective strategies to counter bullying and elitism. Given the proven link between physical and academic achievement we recommend that Ofsted incorporates physical activity criteria in its school inspections.

Probably more important than organised recreation is the role of physical activity incorporated into the fabric of everyday life. We describe as scandalous the failure over 10 years of the Department for Transport to produce its promised walking strategy, and recommend that this is now included in a broader anti-obesity strategy. We also call on the Department of Health to have a strategic input into transport policy. We note the superior conditions for cyclists in other European countries, and whilst not offering detailed prescriptions for boosting cycling and walking levels, commend the Danish town planning we witnessed, notably in respect of proper segregation of cyclists and other road users. A key recommendation we make is for a health impact assessment to be made on major planning proposals which takes due account of the physical activity aspects.

We note the absence of evidence from business to our inquiry and call on the Government to generate awareness of obesity in the business community and on the Treasury to consider fiscal incentives to make the workplace more active.

While environmental solutions are clearly key to tackling obesity at a population level, we also feel that the NHS has an important role to play, both in the prevention and treatment of obesity, but our evidence suggests that this has not been as high a priority for PCTs as it should have been. We have heard of GPs being asked to limit the prescription of NICE-approved obesity drugs, of specialist obesity services with closed waiting lists, and of pioneering local projects threatened with closure due to lack of funding. To address this, we have recommended the establishment of a strategic framework for preventing and treating obesity within the NHS, drawing on existing National Service Frameworks. This should be underpinned by stringent public health targets, and must include the expansion of services to treat obese patients within both primary and secondary care. A full range of treatment options should be open to obese patients, including behavioural or lifestyles approaches, counselling, drug therapy, and, as a last resort, surgery. In particular, children must have access to appropriate services, and should be screened for overweight and obesity annually within a school setting.

Conclusion

In conclusion we note that it is difficult to establish the impact of any individual measure to combat so complex and challenging an issue as obesity; this is not, in our view, an excuse to delay and measures must be taken to tackle the nation's diet and its levels of activity. We acknowledge the responsibility of the individual in respect of his or her own health but believe that the Government must resist inaction caused by political anxiety over accusations of "nanny statism". Government will, after all, have to pay for some of the huge costs that will accrue if the epidemic of obesity goes unchecked. While we have tried wherever possible to take the food industry at its word, and seen it as 'part of the solution', we recommend that the Government reviews the situation in three years and then decides if more direct regulation is required.

1 Introduction

1. With quite astonishing rapidity, an epidemic of obesity has swept over England. To describe what has happened as an epidemic may seem far-fetched. That word is normally applied to a contagious disease that is rapidly spreading. But the proportion of the population that is obese has grown by almost 400% in the last 25 years. Around two-thirds of the population are now overweight or obese. On present trends, obesity will soon surpass smoking as the greatest cause of premature loss of life. It will bring levels of sickness that will put enormous strains on the health service, perhaps even making a publicly funded health service unsustainable.

2. Dr Sheila McKenzie, a consultant at the Royal London Hospital which recently opened an obesity service for children, offered a powerful insight into the crisis posed to the nation's health. Despite only being in existence for three years, her service had an eleven-month waiting list. Over the last two years, she had witnessed a child of three dying from heart failure where extreme obesity was a contributory factor. Four of the children in the care of her unit were being managed at home with non-invasive ventilatory assistance for sleep apnoea: as she put it, "in other words, they are choking on their own fat."[1]

3. A generation is growing up in an obesogenic environment in which the forces behind sedentary behaviour are growing, not declining. Most overweight or obese children become overweight or obese adults; overweight and obese adults are more likely to bring up overweight or obese children. There is little encouraging evidence to suggest that overweight people generally lose weight; there is ample clear evidence that being overweight greatly increases the risks of a huge range of diseases, and that the more overweight people are, the greater the risks. Yet paradoxically, the phenomenal increase in weight comes at a time when there is an apparent obsession with personal appearance. There are more gyms than ever, more options presented as 'healthy eating', and the Atkins diet dominates the best seller charts.

4. Little has been done to reverse trends in obesity. According to Professor Sir George Alberti, President of the International Diabetes Federation, this is partly because the phenomenon has "insidiously crept in" and partly because it raises politically sensitive issues.[2] Dr Geof Rayner, then Chair of the UK Public Health Association, suggested that another issue was the sheer difficulty in knowing how to combat obesity: "when you have big explanations which you cannot pinpoint exactly then it is very difficult to see what you can do about it."[3] For Professor Julian Peto, Head of Epidemiology at the Institute of Cancer Research, another reason for the neglect was the fact that some of the health risks of obesity had not been known for long. In particular, the extent of the link with cancer had only recently emerged following a major US cohort study.[4] Professor Hubert Lacey, for the Royal College of Psychiatrists, argued that part of the problem was stigma and prejudice

1 Appendix 33

2 Q170

3 Q172

4 Q172

against the obese, both within society at large and within the medical profession: "as a group clinically they are not liked … [they are seen as having] brought it on themselves."[5]

5. So rapid has been the rise in obesity that there is a danger it will overtake the population to the extent that what used to be considered 'overweight' starts to become 'normal'. Moreover, as Professor Peto pointed out, "the NHS cannot provide detailed clinical services or intensive clinical services" for the 20% of the population who are obese, and amongst whom two-thirds of the excessive mortality occurs.[6]

6. Society is rapidly changing to absorb the trend in weight. One American airline has started charging obese passengers for two seats.[7] A woman was recently awarded £13,000 compensation from Virgin Atlantic, after developing a large bruise, and muscle and nerve damage which made her bedridden for a month, caused by being wedged next to an obese female passenger for an 11 hour flight.[8] A recent study in Leeds suggested that schoolchildren now require trousers two sizes larger than did their counterparts only 20 years ago.[9] Another report has concluded that 23.6% of British children under four are overweight, compared with 14.7% ten years earlier. A major re-insurance firm has just completed a study concluding that the obese will soon have to pay larger premiums.[10] In America, super-size coffins are now available, and burial plot sizes are increasing.[11]

7. It is often said that Britain lags behind America by a few years in cultural patterns. Trends in obesity in Britain do indeed follow, albeit with a delay of a few years, those in America. And such are the trends in obesity in that country that it is now predicted that one in three American children will eventually become diabetic, which in itself will pose an almost unimaginable disease and cost burden on that country.[12]

8. The Chief Medical Officer has referred to obesity as "a health time bomb" that needs defusing.[13] He noted the World Health Organization (WHO) prediction that the world will "see a one-third increase in the loss of healthy life as a result of overweight and obesity over the next 20 years, with the number of global deaths rising from three million to five million each year."

9. The WHO itself describes an escalating global epidemic of overweight and obesity—"globesity"—that is taking over many parts of the world. In their view, "If immediate action is not taken, millions will suffer from an array of serious health disorders."[14]

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5 Q172, 185

6 Q195

7 *The Times*, 24 Feb 2004

8 *Sunday Times*, 20 October 2002

9 M.C.J. Rudolf et al, "Rising obesity and expanding waistlines in schoolchildren: a cohort study", *Archives of Disease in Childhood*, 89 (2004), pp 235-37

10 *The Guardian*, 7 April 2004

11 *Scotland on Sunday*, 5 October 2003

12 Centers for Disease Control Report presented to 63rd Annual Society, American Diabetes Association

13 Annual Report of the Chief Medical Officer 2002

14 See www.who.int/nut/obs.htm.

10. Should the gloomier scenarios relating to obesity turn out to be true, the sight of amputees will become much more familiar in the streets of Britain. There will be many more blind people. There will be huge demand for kidney dialysis. The positive trends of recent decades in combating heart disease, partly the consequence of the decline in smoking, will be reversed. Indeed, "this will be the first generation where children die before their parents as a consequence of childhood obesity."[15]

Scope and nature of our inquiry

11. We announced our intention of holding an inquiry into obesity on 28 March 2003 with the following terms of reference:

The inquiry will cover:
The health implications of obesity
What are the health outcomes of obesity in society? What are the economic and social costs? What efforts is the Government making to evaluate these?
Trends in obesity
What are the trends in obesity (including trends among particular groups, by social class, age, gender, ethnicity and lifestyle)? What is the relationship between obesity and other health inequalities? What are the international comparisons (EU, OECD, USA)?
What are the causes of the rise in obesity in recent decades?
What has been the role of changes in diet? To what extent have changes in lifestyle, particularly moves to a more sedentary lifestyle, been influential? How much is lack of physical activity contributing to the problem?
What can be done about it?
What is the range of 'levers' and drivers (food industry, marketing, education, family life, genetics, drugs, surgery)? Within that range, what role can the food industry, marketing and advertising, transport and schooling play? What are the responsibilities of the food industry in respect of marketing? How influential is the media? How can the amount of physical activity being undertaken be increased? To what extent can and should Government, at central and local level, influence lifestyle choices? How coherent is national and local strategy? What is international best practice?
Are the institutional structures in place to deliver an improvement?
What is the role of the Department of Health (DoH) and of the NHS, including that of primary care, hospitals and specialist clinics? How effective are the structures for health promotion? Can health promotion compete with huge food sector advertising budgets? To what extent can the food industry be part of a solution? To what extent is the Food Standards Agency influential? How well is the DoH liaising with, and what is the role of, other central and local government departments and bodies? What is the role of schools, including sport in schools? Who should 'own' and drive delivery? Have we the appropriate institutional structures, budgets and priorities?
Recommendations for national and local strategy
How can the Government's strategy be improved? What are the policy options? Can they be better integrated? What are the priorities for action?

15 Appendix 4 (Dr Mary Rudolf); this point was recently echoed by the Chair of the Food Standards Agency. See *The Observer,* 9 November 2003.

12. Since 12 June 2003 we have taken oral evidence on no fewer than 14 occasions making this the most comprehensive inquiry the Health Committee has ever undertaken. We have heard from: Ministers and officials in the Departments of Health (hereafter 'the Department'), Culture, Media and Sport (DCMS), and Education and Skills (DfES); officials from the Food Standards Agency (FSA), the Office of the Deputy Prime Minister (ODPM), the Department for Environment, Food and Rural Affairs (DEFRA) and the Department for Transport; representatives of fast food, carbonated drinks, breakfast cereals and confectionery companies and the advertising agencies representing them; major supermarkets; epidemiologists; experts on obesity, the food industry and physical activity; health professionals; Mr Barry Gardiner MP (who has pioneered a scheme extending the school day to incorporate greater physical activity); and Professor Marion Nestle, Chair of the Department of Nutrition, Food Studies and Public Health, New York University.

13. We received around 150 memoranda from health professionals, representatives of the food industry, academics, advertisers, commercial slimming organizations, those working in sport, recreation and physical activity, and members of the public.

14. We are extremely grateful to all those who submitted written and oral evidence to our inquiry. We are also very grateful to our five specialist advisers: Dr Laurel Edmunds, Senior Researcher for the Avon Longitudinal Study of Parents and Children, University of Bristol; Professor Ken Fox, Department of Exercise and Health Sciences, University of Bristol; Professor Gerard Hastings, Director, Centre for Social Marketing and Centre for Tobacco Control Research, University of Strathclyde; Professor Phil James, Director of the Rowett Research Institute, Aberdeen and Chair of the International Obesity Taskforce; and Tim Lang, Professor of Food Policy, City University. This has been a contentious inquiry, with powerful interest groups carefully watching our work. We are grateful for the objective and expert support we have received from our advisers. We are also very grateful to the Clerk's Department Scrutiny Unit, who provided us with an extremely helpful analysis of the economic costs of obesity, which is annexed to this report. We should also like to thank Liz Powell-Bullock and Adriana Rodriguez for supplementary research for this report.

15. The USA is experiencing particularly disastrous trends in obesity and we wanted to see at first hand what the scale of the problem was and what measures were being taken to address it. Accordingly, in October 2003 we visited the USA. In New York, we met Dr Xavier Pi-Sunyer, a world expert in diabetes at the Obesity Research Center; we visited the Strang Cancer Prevention Center; we met doctors at the New York Presbyterian Hospital, including a representative from the Comprehensive Weight Control Center; we received a presentation from Dr Christine Ren and Dr George Fielding, bariatric surgeons;[16] we met representatives of the New York City Parks Department; finally, we held discussions with Fleishman-Hillard Marketing and Professor Marion Nestle.

16. In Atlanta, Georgia we held discussions with a range of experts from the Centers for Disease Control; we met senior representatives of Coca-Cola; and then met Dr David Satcher, the former Surgeon General of the United States and Director of the Morehouse School of Medicine.

16 Bariatric surgery is surgery on the stomach and/or intestines to help patients with extreme obesity lose weight.

17. Finally we visited Denver, Colorado which leads the national strategy to counter obesity through physical activity, and is the leanest state in America. Here we met representatives of the Colorado Physical Activity and Nutrition Program, the Department of Education, the Healthy Foods/Five-a-day project and the Department of Transportation. We also met Dr James Hill, Director of the America on the Move project, and representatives of Colorado on the Move.

18. Since the EU has a locus in public health in member nations we visited Brussels in December 2003. Here we met David Byrne, EU Commissioner for Health and Consumer Protection, and officials, Mr Andrew Hayes from the International Union against Cancer and the Association of European Cancer Leagues, representatives of the Confederation of the Food and Drink Industries of the EU, and representatives of the European Heart Network.

19. We also visited Finland and Denmark in connection with this and other inquiries. Although Finland experienced substantial growth in obesity in the 1980s and 1990s it has been successful in greatly reducing death through coronary heart disease and has, as a nation, altered its diet and boosted its exercise levels. Although Finland has not managed to reverse the overall growth of obesity, it has managed to reduce the steepness of the curve in trends in obesity in men, and flatten it entirely in women. Finland now has obesity rates lower than England for both males and females. We wanted to see at first hand how it had succeeded in doing that. Denmark has recently agreed a national obesity strategy which could offer many parallels to England.

20. In Finland, we met the Minister for Public Health and officials in the Ministry of Social Affairs and Health, staff and pupils in Pikku Huopalathi school, the National Public Health Institute, Professor Aila Risannen and staff at Helsinki University Central Hospital, and members of the Parliamentary Social Affairs and Health Committee.

21. In Denmark we met officials from the Ministry for the National Board of Health, including the Chief Medical Officer; we also visited the town of Odense which has a particularly advanced transport system, integrating cycle and pedestrian travel.

22. Within England, we undertook a visit to Leeds to witness a specialist obesity clinic, and went to a range of primary and secondary schools to look at physical activity and sport in schools and school meals. We also held informal discussions there with a wide range of health and education professionals. We also visited Bradford Bulls Rugby League Football Club, which has an excellent community outreach scheme, involving children in health education and physical activity.

23. We are extremely grateful to all those, including the Foreign and Commonwealth Office staff, who facilitated these visits which offered crucial evidence to our inquiry, on which we have drawn considerably in formulating this report.

Defining obesity

24. According to the Faculty of Public Health, obesity is "an excess of body fat frequently resulting in a significant impairment of health and longevity."[17] Body fatness is most

17 Ev 46

commonly assessed by body mass index (BMI) which is calculated by dividing an individual's weight measured in kilogrammes by their height in metres squared. We annex, at Annex 2, a chart which will allow readers of this report to calculate their own BMI. Overweight is generally defined as a BMI greater than 25; individuals with a BMI greater than 30 are classified as obese:

Table 1: Classification of Body Mass Index and Risk of Co-morbidities

Classification	BMI (kg/m^2)	Risk of co-morbidities
Underweight	<18.5	Low (but risk of other clinical problems increased)
Normal range	18.5–24.9	Average
Overweight	25.0–29.9	Mildly increased
Obese	**>30.0**	
Class I	30.0–34.9	Moderate
Class II	35.0–39.9	Severe
Class III severe (or 'morbid obesity' or 'super obesity')	>40.0	Very severe

Source: International Obesity Task Force

25. It is important to recognise that obesity is both a medical condition and a lifestyle disorder and both factors have to be seen within a context of individual, family and societal functioning.

26. There is no generally agreed definition of childhood obesity but two widely favoured indicators are based respectively on percentiles of UK reference curves (85th centile for overweight, 95th centile for obesity) and on reference points derived from an international (six country) survey.[18]

27. The correlations between BMI and the risk of co-morbidities in the table above offer a good summary of the situation but also oversimplify it. For example, individuals of South Asian descent have an increased risk of obesity-related disorders, triggered at lower BMI ratios than those above, but this is not taken into account in the current guidelines for obesity management. A BMI of 27.5 or more in an Asian person has been estimated to be associated with comparable morbidities to those in a Caucasian person with a BMI of 30.[19]

28. Central obesity, that is to say a high waist:hip ratio, is another measurement used to define obesity. Central obesity is sometimes defined as a waist:hip ratio greater than 0.95 in

18 In 1990 a nationally representative sample of children had their heights and weights measured. The resulting BMIs were used to generate the UK standard reference charts. The range of BMIs for each sex and age was divided into 100 parts or centiles. For example the 50th centile represents the average BMI, the 3rd centile provides the level at which the thinnest 3% of the population would be identified and similarly, the 97th centile identified the most overweight 3% of the population. Therefore the 85th centile identified the top 15% overweight in the population and 95th the top 5% as obese.

19 World Health Organization expert consultation cited in Royal College of Physicians, *Storing up problems*: *the medical cure for a slimmer nation* (2004), p3.

men and 0.85 in women. A simpler indicator used in a WHO report is that increased risk is present when the waist circumference exceeds 37 inches for men or 32 inches for women.[20]

How prevalent is obesity?

29. Professor Terence Wilkin, of Peninsula University Plymouth, pointed out that over the past 30 years the median body mass of the population has risen as fast as the mean, "suggesting that society is getting fatter, not just those who are already fat."[21]

30. The Health of the Nation targets in 1992 were for fewer than 6% of men and 8% of women to be obese by 2005.[22] The latest figures make disturbing reading, and the trend data show how obesity has more than trebled in the last two decades. These figures are from the Department's own memorandum, updated to take account of data taken from the Health Survey for 2002:

Table 2: Prevalence of obesity in England 1980–2002

Men

Body Mass Index	*1980*	*1993*	*2000*	*2002*
	%	%	%	%
Healthy weight: 20–25		37.8	29.9	29.6
Overweight: 25–30		44.4	44.5	43.4
Obese: Over 30	6	13.2	21.0	22.1
Morbidly obese: Over 40		0.2	0.6	0.8

Women

Body Mass Index	*1980*	*1993*	*2000*	*2002*
	%	%	%	%
Healthy weight: 20–25		44.3	39.0	37.4
Overweight: 25–30		32.2	33.8	33.7
Obese: Over 30	8	16.4	21.4	22.8
Morbidly obese: Over 40		1.4	2.3	2.6

Source: Department of Health (Ev 3) and Health Survey for England 2002

31. Amongst children, one study found that obesity and overweight showed little change between 1974 and 1984, but between 1984 and 1994 overweight increased from 5.4% to 9% in English boys and from 9.3% to 13.5% in girls; the prevalence of obesity reached 1.7% in

20 Cited in National Audit Office (NAO), *Tackling Obesity in England* (2001), p11.

21 Appendix 37

22 Cited in Appendix 18 (Royal College of General Practitioners).

boys and 2.6% in girls.[23] The 2002 Health Survey for England noted a substantial deterioration in the decade subsequent to this study:

> About one in 20 boys (5.5%) and about one in 15 girls (7.2%) aged 2–15 were obese in 2002, according to the International classification. Overall, over one in five boys (21.8%) and over one in four girls (27.5%) were either overweight or obese. In comparison with the International classification, obesity estimates derived by the National BMI percentiles classification were much higher (16.0% for boys and 15.9% for girls). The difference between the two estimates is small for girls when the combined overweight including obesity category is considered (30.7% vs 27.5%), but remains more marked for boys (30.3% vs 21.8%). About one in ten young men (9.2%) and women (11.5%) were obese, while about one in three young men (32.2%) and young women (32.8%) were overweight or obese.[24]

32. Projecting these figures forwards by 15 years simply by assuming a steady growth suggests that around one-third of adults will be obese by 2020. However, "if the rapid acceleration in childhood obesity in the last decade is taken into account, the predicted prevalence in children for 2020 will be in excess of 50%."[25]

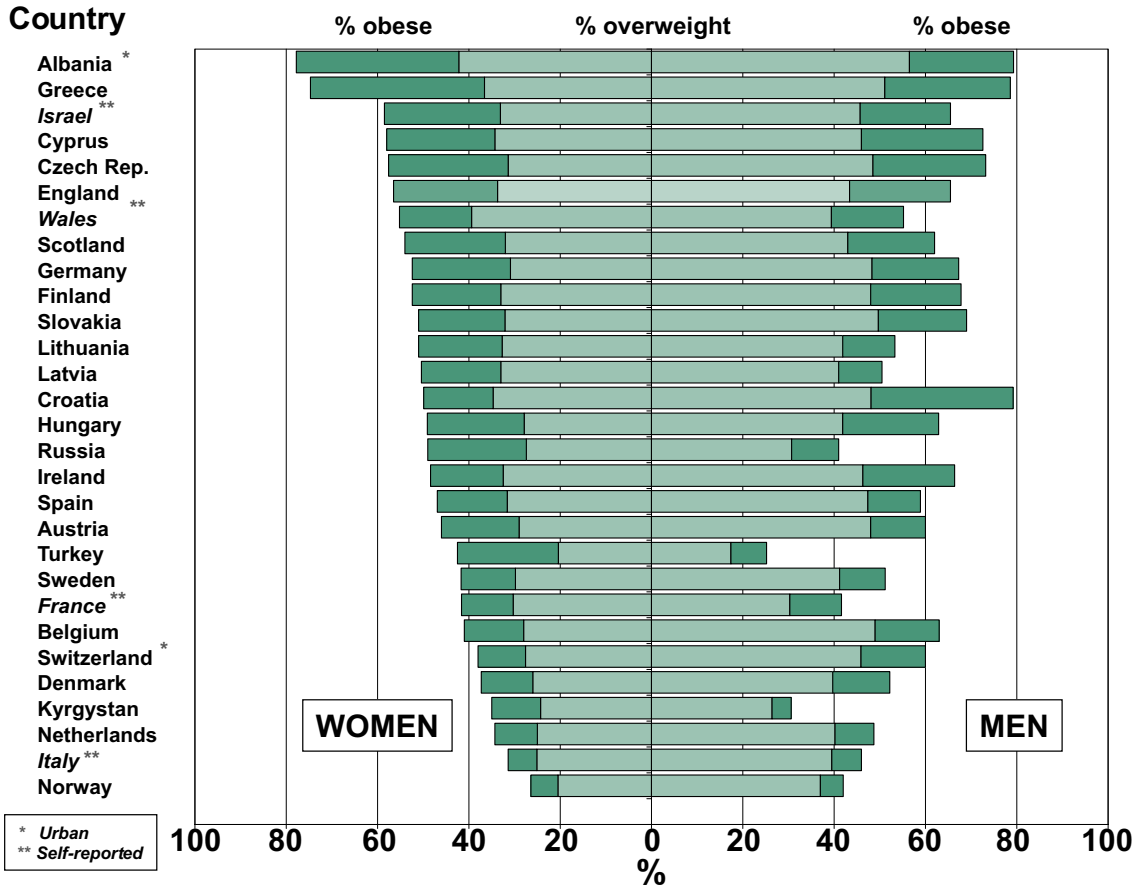
33. The following table lists the prevalence of obesity (defined as BMI above 30) in various European countries:

23 Susan Chinn and Roberto Rona, "Prevalence and trends in overweight and obesity in three cross sectional studies of British children," 1974–94, *British Medical Journal* 322 (2001), pp 24-26

24 Department of Health, Health Survey for England 2002

25 RCP, *Storing up problems*, p4

Figure 1: Obesity levels in Europe



Source: International Obesity Task Force

34. Not only does England have some of the worst figures in Europe but it also demonstrates some of the worst trends in the acceleration of obesity: in the majority of European countries the prevalence of obesity has increased between 10–40% in the last ten years, but in England it has more than doubled.

35. In 1995, according to the WHO, there were an estimated 200 million obese adults worldwide and another 18 million children aged under five classified as overweight.[26] However, by 2000, the number of obese adults had increased to over 300 million.

36. Contrary to conventional wisdom, the obesity epidemic is not restricted to industrialised societies. Some 115 million people suffer from obesity-related problems in the non-industrialised world. For example:

- Over three-quarters of men living in cities in Samoa are obese;
- There are as many overweight as underweight adults in Ghana;
- 44% of women in the Cape Peninsula of South Africa are obese.[27]

26 www.who/int/nut

27 International Obesity Taskforce—see www.iotf.org .

37. There is enormous variation in obesity rates even within countries with the highest GDPs. The USA is near the top of any table of obesity rates but Japan is nearer the bottom. Despite the entry of US-style eating chains in Japan, its food culture has proved sufficiently robust so far to resist some of the global trends in obesity. This cultural dimension is important: obesity should not be seen as an inevitable result of economic advance. However, it is true to say that, as countries develop, there is a marked shift in the proportion of the population who are overweight as opposed to underweight. Ironically, in many countries the problem of malnutrition is being superseded or complemented by the problem of obesity.

Obesity and health inequalities

38. In common with most public health problems the impact of obesity mirrors many other health inequalities. Men and women working in unskilled manual occupations are over four times as likely as those in professional employment to be classified as morbidly obese.[28] The Health Survey for England has shown that in 2001 amongst professional groups 14% of men and women were obese, compared to 28% of women and 19% of men in unskilled manual occupations.[29] Children who are Asian are four times more likely to be obese than those who are white.[30] Pakistani, Indian and Bangladeshi men have relatively low levels of obesity measured by BMI, but 41% of Indian men are classed as centrally obese compared to 28% of men in the general population.[31]

39. Amongst women, there are also important differences between ethnic groups: in 1999 obesity was 50% higher than the national average amongst Black Caribbean women and 25% higher amongst Pakistani women.

What are the potential health risks of obesity and what are the costs of these?

40. There is a nine-year reduction in life expectancy amongst obese patients, the risk being markedly amplified if they also smoke. Generalised obesity (fat distributed around the whole body) results in alterations in the blood circulation and heart function, while central/abdominal obesity (fatness mainly around the chest and abdomen) further restricts chest movements and alters breathing function. Fat around the abdomen is also a major contributor to the development of diabetes, hypertension, and alterations in blood lipid (fat and cholesterol) concentrations.[32]

41. Overweight and obesity are associated with a wide range of conditions as the table below shows:

28 Appendix 5 (British Medical Foundation)

29 Chief Medical Officer's Report, 2002

30 Appendix 29 (Medical Research Council)

31 Ev 115

32 *Storing up problems*, p 7

Table 3: Relative risks of health problems associated with obesity[33]

Greatly increased (relative risk much greater than 3)	*Moderately increased (relative risk 2–3)*	*Slightly increased (relative risk 1–2)*
Type 2 diabetes	Coronary Heart Disease	Cancer (breast cancer in postmenopausal women, endometrial cancer, colon cancer)
Gallbladder disease	Hypertension	Reproductive hormone abnormalities
Dyslipidaemia	Osteoarthritis (Knees)	Polycystic ovary syndrome
Insulin resistance	Hyperuricaemia and gout	Impaired fertility
Breathlessness		Low back pain
Sleep apnoea		Anaesthetic risk
		Fetal defects associated with maternal obesity

Source: WHO (1998)

42. According to the 2002 WHO World Health Report: "Overweight and obesity lead to adverse metabolic effects on blood pressure, cholesterol, triglycerides[34] and insulin resistance. Risks of coronary heart disease, ischaemic stroke and type 2 diabetes mellitus increase steadily with increasing BMI." Raised BMI also "increases the risk of cancer of the breast, colon, prostate, endometrium, kidney and gallbladder."[35]

43. In non-smokers, the relative risk of death has been estimated to rise in relation to increased body weight by the following factors:

Table 4: Classification of Body Mass Index and Relative Risk of Death

BMI	Relative risk of death
25–26.9	1.3
27–28.9	1.6
29–31	2.1

Source: RCGP (Appendix 18)

44. Overweight and obesity are regarded as amongst the main modifiable risks associated with **coronary heart disease (CHD) and cardio-vascular disease generally**. The British Heart Foundation estimates that around 5% of CHD deaths in men and 6% in women are due to obesity as such[36] and a higher proportion if the large number of overweight adults is also considered.

45. Perhaps the most dramatic impact has come in the area of **diabetes**. Already there are over two million diabetics living in the UK (only around half of whom will have had the disease diagnosed); that figure is projected to rise to three million by 2010.[37] Worldwide, the number of diabetics is projected to rise from 200 to 300 million over the period 2000 to 2020.[38] The prevalence of diabetes has increased by 65% in men and 25% in women since

33 All relative risk estimates are approximate. The relative risk indicates the risk measured against that of a non-obese person. For example, an obese person is two to three times more likely to suffer from hypertension than is a non-obese person.

34 Triglycerides are blood fats.

35 WHO, World Health Report 2002, p 60

36 Appendix 5

37 Appendix 23 (Diabetes UK)

38 Appendix 3; Q216 (Professor Alberti)

1991.[39] It represents a massive and growing threat to public health, given that typically the gap between onset and diagnosis of the disease is 9–12 years. Already, some 20% of the South Asian population is diabetic and 25% are glucose-intolerant, a precursor condition for diabetes. On some projections, by 2025 diabetes could account for a quarter of the health budget.[40]

46. Obesity triggers a state of insulin resistance. Professor Terence Wilkin, from Peninsula University, Plymouth, and Director of the Early Bird Study which seeks to establish the factors in childhood that lead to insulin resistance and diabetes, suggested that hyperinsulinaemia drives a host of metabolic disturbances besides diabetes:

> [these are known as:] the metabolic syndrome, and include hypertension, hypercholesterolaemia, hypertriglyceridaemia, hypercoagulation, hyperviscosity and hyperuricaemia. Each in itself is a risk factor for coronary artery disease, but together they are catastrophic—the so-called syndrome X [or metabolic syndrome].[41]

47. Professor Wilkin concluded that, rather than being a "complication" of diabetes, premature cardiovascular disease is an "inevitable association" of the condition.

48. Whereas type 2 diabetes was hitherto normally associated with diabetes developing in adults over the age of 35—it was often termed "late onset" or "adult onset" diabetes—it is increasingly being diagnosed in children.[42] One estimate suggests that up to 45% of cases of diabetes diagnosed in children in the USA are now type 2.[43] As Professor A H Barnett, Clinical Director for Diabetes and Endocrine Services at the University of Birmingham, noted: "figures from the USA … indicate a very serious long-term outlook for these children, with significant numbers dying from heart attack or being on kidney dialysis and/or blind before the age of 40 years."[44] Dr Tim Barrett, a paediatrician at Birmingham Children's Hospital, told us that it was only since about the year 2000 that the medical profession had started seeing children with type 2 diabetes in England, but that this disease now accounted for about 6% of the children attending his clinic with diabetes. The youngest patient he had seen, who had developed some symptoms, was a super-obese eight year old girl.[45]

49. The progress of diabetes is so closely entwined with that of obesity that in America it has produced the coinage "diabesity".[46] Diabetes leads to cardio-vascular problems, and can also entail blindness following damage to the small blood vessels of the eye, kidney failure, stroke, osteoarthritis, and damage to the nervous system which can lead to leg ulcers and limb amputation. A long-term study of 51 Canadian patients aged 18–33 years diagnosed with type 2 diabetes before the age of 17 years found that:

39 Ev 115 (National Heart Forum)

40 Appendix 3 (Professor A Barnett)

41 Appendix 37

42 Type 1 diabetes used to be known as "juvenile diabetes". It is an auto-immune disease, now representing less than 10% of diabetes world-wide.

43 A Pagota Campagna, "Emergence of type 2 diabetes mellitus in children: epidemiological evidence", *Journal Paediatric Endocrinology and Metabolism* 13 (2000), supplement 6, pp 1395-1402

44 Appendix 3

45 Q195

46 *The Guardian*, 10 May 2003, "Food: The way we eat now", p17

> Seven had died; three others were on dialysis; one became blind at the age of 26; and one had had a toe amputation. Of 56 pregnancies in this cohort, only 35 had resulted in live births (62.5%).[47]

50. Children contracting type 2 diabetes will also have a life-time to develop the severe sequelae of the disease and their diabetes is much more difficult to control than those children developing the classic form of type 1 diabetes with insulin deficiency.

51. It is crucial to realise that for diabetes—and indeed many of the conditions listed here—it is not necessary to be *obese* to increase the risk of morbidity. Risks rapidly accelerate as people become *overweight*. As Professor Andrew Prentice, Head of the Medical Research Council's International Nutrition Group at the London School of Hygiene and Tropical Medicine, noted, "If you look at the risks for diabetes … [in] people with a BMI that does not classify them as clinically obese (a BMI of around 28 in women) the increased risk of diabetes is 18-fold."[48] But risks continue to accelerate as BMI grows. According to Professor Sir George Alberti, President of the International Diabetes Federation, a study of nurses in the USA has revealed that those with a BMI of 35 had "a 92-fold increase in risk of diabetes" compared with those with a BMI of 22.[49]

52. Diabetes is also associated with health inequalities: diabetes is three to five times more common in people of African and Caribbean origin living in the UK.[50]

53. Professor A H Barnett estimated that diabetes "now costs the Exchequer around 9% of the total healthcare budget of the UK, with projections that by 2025 that this could reach 25% of the total healthcare budget."[51]

54. **End-stage renal failure** is a complication of diabetes. According to the National Kidney Federation, renal failure is set to increase massively: yet already services in the UK are "overwhelmed" in terms of capacity and financial resources.[52]

55. Around 14% of **cancer** deaths in men and 20% in women are attributed to obesity.[53] Obesity is associated with breast, endometrial, oesophageal and colonic cancers.[54] According to Professor Julian Peto, for the Institute of Cancer Research, obesity is "far and away the most important avoidable cause" of cancer in non-smokers.[55] Cancer Research UK suggested that 1 in 7 cancer deaths in men and 1 in 5 in women in the USA, are attributable to overweight and obesity. This implies that 1 in 8 UK cancer deaths are thus caused. The clear association between obesity and cancer, in the view of the charity, is

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47 H Dean and B Flett, "Natural History of type 2 diabetes diagnosed in childhood: long term follow-up in young adult years", *Diabetes* 2002:51 (suppl 2) A24-25, cited in RCP, *Storing up problems: the medical case for a slimmer nation*, 2004, p 8; Q195 (Dr Barrett)

48 Q362

49 Q174

50 Appendix 23 (Diabetes UK)

51 Appendix 3; see further C J Currie et al, "NHS acute sector expenditure for diabetes: the present, future and excess in-patient cost of care,"*Diabetic Medicine*, 14 (1997), pp 686-92

52 Appendix 1

53 Appendix 11 (UK Association for the Study of Obesity)

54 Q174; Q178

55 Q210

"poorly acknowledged outside the scientific community".[56] A recent survey showed that only 3% of the population was aware of the link between overweight and cancer even though this factor is the main preventable risk factor after tobacco use, and will eventually become the main risk factor.[57] Professor Peto cited a Framingham study which suggested that in female non-smokers who are obese life expectancy is seven years shorter.[58]

56. The National Obesity Forum presented evidence to suggest that around 20 different cancers have been linked to obesity. They also noted that in the morbidly obese, death rates from cancer were 52% higher for men and 60% higher for women.[59]

57. **Osteoarthritis**, a joint disorder which typically affects the joints in knees, hips, and lower back, is exacerbated by overweight. Weight gain appears to increase the risk of osteoarthritis by placing extra pressure on these joints and wearing away the protective cartilage. **Back pain**, one of the commonest health problems caused or exacerbated by overweight and obesity, leads to more than 11 million lost working days each year in Britain.[60]

58. **Psychological damage** caused by overweight and obesity is a huge health burden. In childhood, the first problems caused are likely to be emotional and psychological.[61] Moreover, the psychological consequences of obesity can range from lowered self-esteem to clinical depression. Rates of anxiety and depression are three to four times higher among obese individuals.[62] Obese women are around 37% more likely to commit suicide than women of normal weight.[63]

59. The seminal 2001 National Audit Office (NAO) Report, *Tackling Obesity in England*, noted:

> Obese people … are more likely to suffer from a number of psychological problems, including binge-eating, low self-image and confidence, and a sense of isolation and humiliation arising from practical problems.[64]

60. Professor Hubert Lacey, for the Royal College of Psychiatrists, told us that depression tended to be caused by obesity, rather than obesity by depression:

> There is not a clear link between massive obesity and a pre-existing psychological problem; rather there is evidence of psychological sequelae from the massive obesity itself.[65]

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56 Ev 57

57 NOP poll for Cancer Research UK. See BBC News UK, 5 April 2004.

58 Q212

59 Ev 318

60 BBC health website at www.bbc.co.uk

61 Appendix 20 (Royal College of Paediatrics and Child Health)

62 IOTF website at www.iotf.org

63 Appendix 6 (Roche)

64 *Tackling Obesity in England*, p 56

65 Q182

This professional analysis is the opposite of that held by the public and indeed by many doctors.

61. Excess weight is also likely to lead to prejudice in the workplace, lower self-esteem and reduced job opportunities. According to Professor Jane Wardle, of the Health Behaviour Unit at University College London, a recent study has demonstrated that teachers underestimate the IQ of overweight children.[66]

62. One recent study has concluded that "Mortality attributable to excess weight is a major public health problem in the EU. At least one in 13 annual deaths in the EU are likely to be related to excess weight." However, in that figure the UK has the highest individual percentage of all, with 8.7% of deaths being attributable to excess weight.[67]

What are the economic costs?

63. The NAO estimated that the direct cost of treating obesity and its consequences in 1998 was £480 million (1.5% of NHS expenditure) and that indirect costs (loss of earnings due to sickness and premature mortality) amounted to £2.1 billion, giving an overall total of £2.58 billion. A total projected figure of £3.6 billion was given for 2010. Although these figures have been widely quoted in much subsequent work on obesity, the authors consistently acknowledge the conservative nature of their estimates.[68]

64. We asked the House of Commons Clerk's Department Scrutiny Unit to revisit the NAO calculations and analyse them so as to produce a more up-to-date and comprehensive analysis of the costs of obesity. Their work is annexed to this report at Annex 1.

65. However, in summary the findings of the Scrutiny Unit were as follows:

- The calculations of the cost of obesity made in the NAO report *Tackling Obesity in England* are said to be conservative and underestimates by its authors.
- Estimates of the cost of obesity from other countries are nearly all well above those for England, as a proportion of healthcare spending, even though obesity levels were generally lower.
- The direct cost of treating obesity in England in 2002 is estimated at £46–49 million.
- The costs of treating the consequences of obesity are an estimated £945–1,075 million.
- The indirect costs of obesity in 2002 are estimated at £1–1.1 billion for premature mortality and £1.3–1.45 billion for sickness absence.

66. **The Clerk's Department Scrutiny Unit has recalculated the total estimated cost of obesity is therefore £3.3–3.7 billion. This is £0.7–1.1 billion (27–42%) more than the NAO estimate for 1998. The difference between the two figures occurs for a number of**

66 Q189

67 See J R Banegas et al, "A simple estimate of mortality attributable to excess weight in the European Union", *European Journal of Clinical Nutrition*, 57 (2003), pp 201-8.

68 *Tackling Obesity in England*, para 2.27; see also appendix 6 paras 17-18, 22, 25, 28 and 33-34.

reasons including higher NHS and drug costs, more accurate data that have been produced recently, the inclusion of more co-morbidities and the increased prevalence of obesity. This figure should still be regarded as an under-estimate. We note that these analyses are for the 20% of the adult population who are already obese. If in crude terms the costs of being overweight are on average only half of those of being obese then, with more than twice as many overweight as obese men and women, these costs would double. This would yield an overall cost estimate for overweight and obesity of £6.6–7.4 billion per year.

2 Causes

> **What has happened in our environment in terms of the history of human evolution is remarkable in the last two generations. We have never seen anything like this, where we have the coming together of the technological, electronic, television revolution and the highly available, high energy-dense and very cheap foods … where physical activity comes in is that you rapidly get into a vicious cycle of inactivity, sloth and weight gain: as soon as you start to gain a load of weight, it is all the more difficult to go up those stairs; as soon as you start to become a little less fit, you resist doing those things which in the first place will help you not to become overweight, and so it rapidly becomes a vicious cycle.[69]**
>
> *Professor Andrew Prentice*

Gluttony or sloth?

67. Determining the root causes of obesity is central to any efforts to tackling it, and, according to an influential paper published in 1995 by two of our witnesses, Susan Jebb and Andrew Prentice, scientists at the Medical Research Council Human Nutrition Research Centre, "uncertainty over the aetiology of obesity remains one of the chief barriers to designing effective strategies for prevention and treatment."[70] Although much research has been carried out into the potential influence of genetic factors, such as possible metabolic defects, these have been largely abandoned, particularly as the dramatically escalating rate of obesity documented in recent years has occurred in a relatively constant gene pool. Instead, the key question remains that articulated by Susan Jebb and Andrew Prentice in 1995:

> It is certain that obesity develops only when there is a sustained imbalance between the amount of energy consumed by a person and the amount used up in everyday life. But which side of this energy balance equation has been most altered in recent decades to produce such rapid weight gain? Should obesity be blamed on **gluttony**, **sloth**, or both?[71]

68. It is clear that people are overeating in relation to their energy needs, and that the cheapness, availability and heavy marketing of energy-dense foods makes this very easy to do, coupled with an increasing reliance on snacks and ready-prepared meals which makes selecting 'healthy' foods[72] harder. However, according to Jebb and Prentice:

69 Q296

70 "Obesity in Britain: gluttony or sloth?" *BMJ* 1995;311:437-439 (12 August)

71 Ibid

72 In this report we refer at times to 'healthy' and 'unhealthy' foods. Below we discuss in detail the arguments surrounding the use of these terms. We are ourselves satisfied that they are appropriate descriptions and that most experts and indeed the public at large would accept them. Unhealthy foods tend to be energy-dense, and high in fats, sugars and/or salts.

> The paradox of increasing obesity in the face of decreasing food intake can only be explained if levels of energy expenditure have declined faster than energy intake, thus leading to an over-consumption of energy relative to a greatly reduced requirement.[73]

69. Summing up the energy equation, the Royal College of General Practitioners suggested that food intake had fallen on average by 750 kcal per day; but activity levels by 800 kcal. Out of this small imbalance has come the wave of obesity.[74]

Nutritional causes

Changing nutritional habits

70. Although, according to Jebb and Prentice, "it is generally assumed that ready access to highly palatable foods induces excess consumption and that obesity is caused by simple gluttony", in their view the National Food Survey in fact points to an overall drop in energy consumption since the 1970s.[75] Even after adjustments for meals eaten outside the home, and for consumption of alcohol, soft drinks and confectionery, average per capita energy intake seems to have declined by 20% since 1970. The food industry has been quick to seize upon this evidence to point the blame for spiralling rates of obesity firmly on reductions in physical activity. However, this argument ignores many other complex changes in people's nutrition patterns that have taken place in recent years, and masks the important contribution that nutrition makes to obesity. Andrew Prentice was himself displeased by this use of his research by what he termed "rogue elements of the food industry":

> We have been less than pleased at the way that paper has been wilfully misused by certain parts of the food industry, saying, "It is nothing to do with our products, it is nothing to do with food; it is all down to physical inactivity." [76]

71. An important note of warning is that the data used for the National Food Survey are self-reported, and, notoriously, individuals are reluctant to report consumption of foods they regard as being bad for them. As Tim Lobstein, for the Food Commission demonstrated:

> the latest national diet survey says [adults] are eating 82 grams of confectionery each week, self-reported. If you look at industry sales figures, those are 250 grams per week being sold to somebody. Clearly there is a huge gap between what industry is selling and what people are reporting they are eating.[77]

72. **Given the profound significance of overweight and obesity to the population we believe it is essential that the Government has access to accurate data on the actual calories the population is consuming, including figures for confectionery, soft drinks, alcohol and meals taken outside of the home. Although we acknowledge the difficulties**

73 "Obesity in Britain: gluttony or sloth?" *BMJ* 1995;311:437-439 (12 August)

74 Appendix 18

75 "Obesity in Britain: gluttony or sloth?" *BMJ* 1995;311:437-439 (12 August)

76 Q282

77 Q294

of obtaining accurate data, given the limitations of any self-reported survey, the current information is very weak and clearly underestimates actual calorie consumption. We recommend that work is urgently commissioned to establish a Food Survey that accurately reflects the total calorie intake of the population to supersede the flawed and partial analysis currently available. The Food Standards Agency and Scientific Advisory Committee on Nutrition should advise on this.[78]

73. Even if overall calorie consumption has fallen, there have been significant changes in the composition of people's diets. Firstly, there has been an increase in the proportion of fat in the British diet: in the 1940s, each kJ of carbohydrate in the diet was associated with 0.6 kJ of fat but in the 1990s with 0.9kJ of fat, an increase of 50%.[79] Although both carbohydrates and fats produce energy, exactly where and how people take in their energy has a crucial role in obesity.

74. During the course of this inquiry, the food industry has made constant use of the formulaic argument that 'there are no such thing as unhealthy foods, only unhealthy diets', a phrase we have also, perhaps surprisingly, heard from sports officials and Government ministers. But it is patently apparent that certain foods are hugely calorific in relation to their weight and/or their nutritional value compared to others:

Weight and calorie content of snack foods[80]

Snacks	*Weight*	*Calories*
Bag of Walkers crisps	35g	183
Snickers bar	61g	280
Apple	112 g	53

75. Besides portion size, calorie content is determined largely by fat, sugars and other refined carbohydrate content. More important than the total amount of energy (or calories) a food has is how much energy it contains in relation to its weight, that is to say its *energy density*. Put simply, energy density is a measure of a food's calories in relation to its total volume, and relates to how satiating, or filling, a food is. For example, a king size Snickers bar, which weighs 100g, has more calories than a main meal of sirloin steak served with potatoes and broccoli, which has a total weight of 400g.[81] Its high energy density means that the Snickers bar, although it is highly calorific, is not correspondingly filling, and so does not send the brain signals telling a person to stop eating in the same way that a filling main meal would. Foods that are high in energy density, and in particular high in fat, have only very weak effects on satiety —that is they do not fill you up. A Snickers bar, although it is in fact as calorific as some main meals, would typically be eaten as a snack

78 The Scientific Advisory Committee on Nutrition is an advisory committee of independent experts that provides advice to the Food Standards Agency and Department of Health as well as other Government Agencies and Departments. Its remit includes matters concerning nutrient content of individual foods, advice on diet and the nutritional status of people. See www.sacn.gov.uk.

79 Andrew Prentice and Susan Jebb, "Obesity in Britain: Gluttony of Sloth?", *BMJ*, 311 (1995), pp 437-39.

80 www.walkers.corpex.com; www.snickers.co.uk; www.weightlossresources.co.uk

81 Collins Calorie Counter

between meals, and a person in the habit of having a Snickers bar with their mid-afternoon cup of tea could arguably be said to be having four meals a day rather than three.

76. According to Professor Prentice, humans have evolved to have an "asymmetry of appetite control", often described as the 'thrifty genotype' theory:

> We are very good at recognising hunger—it is an evolutionary obligatory fact that we should respond to hunger very well—we are very bad at recognising satiety. Indeed, if you think it through, we are almost predesigned to lay down fat.[82]

77. While in times of uncertain food availability this asymmetry could help people survive famines, in today's environment, it is very conducive to weight gain. Professor Prentice explained that while it does not necessarily pose problems for people who are very physically active, who are generally able to control their weight successfully on their hunger drive, the reverse is true for people who are very physically inactive: "the environment is pressing on you much more food than you need and your body, physiology, is just not designed to stop it; in fact it is designed to say, 'Thank you very much, I will lay that down as fat.'"[83]

78. Professor Prentice went on to describe to us how controlled experiments demonstrated this phenomenon:

> You have experimental volunteers who you ask to eat normally but you secretly change the content of their foods—then, as soon as you add fat in and increase the energy density they overeat. It is extremely easy to replicate under any experiment: they automatically overeat. The reason they do this is they continue to eat the same bulk of food, the same amount of food, without recognising—their bodies simply do not recognise—that it has more calories, more energy in it.[84]

79. While the energy density of soft drinks, which are frequently highly calorific, needs to be considered differently from that of solid foods, recent research has demonstrated that consumption of soft drinks is likely to increase normal caloric intake—in other words, when people consume soft drinks, they do not recognise that they have taken in extra energy and compensate by reducing energy from elsewhere in their daily diet, or by expending additional energy; they simply add it on.[85] A standard 330 ml can of Coca-Cola contains 139 calories. Thus if a person were to consume a can of Coca-Cola with two meals per day, over a week that would result in an energy surplus of nearly 2,000 calories—more than a whole day's recommended calorie intake for the average woman, and about three-quarters of the recommended daily calorie intake for a man. Evidence from the British Soft Drinks Association suggests that children drink an average of 4.7 litres of soft drink per week, of which only 10% are fruit juice or water.[86]

82 Q287

83 Q287

84 Q288

85 Q290

86 Appendix 22; Appendix 14 (Professor John Blundell)

80. Recently, the thesis that unhealthy food may have specific addictive properties has also been explored. John Blundell, Professor of Psychobiology at the University of Leeds, has argued that while there are fundamental differences between the brain's response to food and to addictive drugs, the pleasure and the positive reinforcement people obtain from eating food could lead to the development of a compulsive element to food consumption.[87] According to Susan Jebb, this is fostered not only by the taste of food but by "the whole aura surrounding food, the marketing, the lifestyle that you buy into."[88]

81. The past 20 years have seen considerable changes not simply to what people eat and how much, but also to the ways in which they eat. Snacking, eating out, and reliance on convenience food have all increased dramatically. These changing patterns of consumption are in part a response to the far reaching social changes of the last 50 years, including a greater number of women working outside the home, longer working hours, and higher levels of disposable income. However, while these changing eating patterns may not of themselves be a problem, they can be conducive to obesity.

82. Readily available snack foods and drinks are typically very energy-dense, and are usually consumed to supplement rather than replace meals, despite their high calorie content. Between 1993–98, sales of snacks to adults more than tripled in the UK, from £173 million to £541 million.[89] As the Department pointed out in its memorandum, British people now consume an increasing number of meals outside the home, with 25% of respondents to a consumer attitudes survey saying that they regularly used some form of fast food or takeaway outlet.[90]

83. There is also increasing consumer demand for convenience food, and a growing trend towards snacking and eating on the move. The average time spent preparing a meal in 1983 was an hour, but today it has shrunk to 13 minutes.[91] In the period 1990–2000 alone, purchases of convenience foods rose by 24%.[92] According to market analysts Mintel, between 1998–2002, demand for ready meals in Britain grew by 44%, compared to 29% growth across Europe as a whole, and figures suggest that Britain is now consuming the highest number of ready meals in Europe, double the amount consumed in France, and six times that in Spain.[93]

84. Eating ready prepared snacks or meals, whether pre-packed meals which are heated up at home, or food purchased from a restaurant or fast food outlet, reduces a consumer's choice and control over what they eat. When preparing a meal from scratch, a consumer will have full control over how much fat, sugar and other ingredients are put into the dish, control over what quantity to make, and over the portion size that is served. Buying a snack such as a bag of crisps, or a ready-prepared meal to heat up, effectively removes those

87 Q367 (Susan Jebb)

88 Q367

89 http://news.bbc.co.uk/1/hi/business/your_money/102413.stm

90 Ev 9

91 "Can't Cook. Won't Cook. Don't Care. Going Out", *The Times*, 17 November. 2003

92 National Food Survey 2001

93 http://news.bbc.co.uk/1/hi/uk/2787329.stm

choices. People eating out in a restaurant are even less likely to be aware of the fat or calorie levels of the meal they have ordered.

85. Consumption of alcohol, particularly amongst women and young people, has increased dramatically during the past years.[94] With most alcoholic drinks being at least as calorific as a high-sugar soft drink, such as Coca-Cola, it would seem intuitive that the massive increase in their consumption has had some impact on the nation's weight. Much attention has focused in recent months on the growing culture of 'binge drinking', particularly amongst young people. While the health risks associated with this are well documented, what is less publicised is that drinking five pints of lager over an evening adds an extra 1,135 calories, nearly half a man's daily energy requirement, and five bottles of an 'alcopop' such as Bacardi Breezer contain 990 calories, nearly half a woman's daily energy requirement.[95]

86. During the course of our inquiry, we have been continuously surprised by the lack of emphasis given to the impact of alcohol consumption on obesity. While the Department, and most experts who gave evidence to us were in no doubt that it must have an impact, there seemed very little definitive evidence in this area. We were also concerned to note that the Government's recent Alcohol Strategy made no mention whatsoever of the potential impact of alcohol consumption on weight gain, leading to a further set of health problems in addition to those already linked directly to alcohol.[96]

87. **The relationship between alcohol consumption and obesity is too little understood. We recommend that the Department of Health commissions research into the correlation between trends in alcohol consumption and trends in obesity.**

Information and choice

88. What people consume is, at its simplest level, determined by personal choice. However, changing lifestyles have made the nutritional environment, spanning supermarkets selling ready meals, restaurants, sandwich bars and fast food outlets, increasingly complex, and this means that making healthy, informed choices about nutrition is more complicated than ever. The nutritional environment of the United States was described in stark terms by Marion Nestle, from the Department of Nutrition, Food Studies and Public Health, New York University, who argued that American society had changed in ways that made it "much, much too easy for people to over-eat":

> Food is extremely cheap in our country, and there are many, many driving forces keeping the cost of foods extremely low. Low-cost food encourages people to eat more. Food is extremely convenient; it is ubiquitous; it is available all day, 24 hours a day, 7 days a week; and it is available in larger and larger portions … Every single one of those aspects encourages people to eat more, and there is a considerable amount of research that demonstrates that. We have created a societal environment in which it is considered totally acceptable for people to eat anywhere, to eat all day long and

94 Ev 8

95 http:/www.weightlossresources.co.uk/calories/calorie_counting/christmas_alcohol.htm

96 *Alcohol Harm Reduction Strategy*, Cabinet Office, March 2004

> to eat in larger and larger quantities; all of which encourages people to eat more and to gain more weight.[97]

89. While the UK may be some way behind the US in terms of its obesity epidemic, our evidence suggests that the information and tools consumers require to negotiate a changed nutritional environment have not kept pace with those rapid changes, and that frequently external factors are directing consumers towards unhealthy rather than healthy choices.

90. Information and education are clearly key to making healthy choices about what and how much to eat. Yet although the evidence-base about what constitutes a healthy diet has been well developed for many years, it is clear that people are not adhering to healthy eating recommendations. According to the Food Standards Agency (FSA), British children eat fewer than half the recommended portions of fruit and vegetables a day, and the vast majority have intakes of saturated fat, sugar and salt which exceed the maximum adult recommendations.[98]

91. Why, then, are these messages not getting through? Perhaps they are not being delivered loudly or consistently enough, meaning people are simply unaware of how to balance foods to make up a healthy diet that does not lead to weight gain. Alternatively, people may be insufficiently aware of the devastating health consequences associated with being overweight or obese. According to Tim Lobstein of the Food Commission healthy eating messages are well known, but external pressures prevent people from adhering to them:

> When I go and give talks to even low-income families, they are fairly well aware of the sorts of things they ought to be eating more of, but they are not doing it and they are not doing it for a variety of cultural and economic reasons—and also for children there are fashionable reasons and so on. There are a number of other pressures besides the health education message that are encouraging them away from healthy eating.[99]

92. We address these other pressures, including commercial food promotion and food pricing later in this chapter.

93. In addition to a good theoretical understanding of what constitutes a healthy diet, being able to prepare a healthy meal is a cornerstone of healthy eating habits. Yet we have received evidence suggesting that a growing number of British people lack the basic skills and confidence to do this. The Nutrition Society also argued that the "lack of ability to cook amongst the school generation means that people are not as in control of their food supply as they might be."[100] Focus on Food echoed these sentiments by stressing that dietary behaviour could not be changed without teaching people relevant skills such as cooking, which reduce the reliance on high-fat, high-salt, processed foods.[101] The need for such skills to be taught is all the more marked, given that, for the first time, the current

97 Q461

98 Food Standards Agency, (June 2000), *The National Diet and Nutrition Survey of Young People aged 4 to 18 years*, HMSO, London

99 Q303

100 Appendix 13

101 Appendix 34

generation of children is being raised by parents whose main experience of cooking is preparing convenience foods, thus removing a major source of food education from children.

94. The national curriculum currently includes Food Technology under the remit of Design and Technology, and this covers learning about food preparation, food hygiene and the design of food products. Food Technology is compulsory up until the age of 11, but after that there is no compulsion for any practical cooking skills or food education to be learnt. Moreover the Qualification and Curriculum Authority states that the focus of Food Technology should be on manufacturing and processing food rather than practical cooking skills.

95. The dire state of cookery provision has led to a number of initiatives where mobile facilities for cookery teaching, dubbed 'Cooking Buses', travel to schools providing lessons for children and training for teachers. The existence of these schemes has clearly tapped into an unmet need and enthusiasm for cookery training at school, as many of these schemes have waiting lists of over a year.[102]

96. Even if people are well aware of what constitutes a healthy diet, and have full information about the nutritional value of what they are eating, their decision-making does not take place in a vacuum. Any health information about nutrition that consumers currently receive is heavily counterbalanced by advertising and promotion campaigns undertaken by the food industry.

Table 5: Advertising spend across the top ten advertised food brands in the UK (2002)

	Spend (£'s)	% of Total
MCDONALDS – Fast-food restaurant	41,973,066	9.3%
COCA COLA, ORIGINAL COKE – Soft-drink	15,531,274	3.4%
KENTUCKY FRIED CHICKEN – Fast-food restaurant	15,140,219	3.3%
BURGER KING – Fast-food restaurant	11,168,498	2.5%
PIZZA HUT – Fast-food restaurant	9,357,014	2.1%
COCA COLA, DIET COKE – Soft-drink	7,395,695	1.6%
PRINGLES, CRISPS – Savoury-snack	6,700,914	1.5%
KIT-KAT, CHOCOLATE BAR – Confectionery	6,469,021	1.4%
WEETABIX – Breakfast Cereal	6,366,666	1.4%
KELLOGG'S, CORN FLAKES – Breakfast Cereal	6,263,369	1.4%
TOTAL (all food brands)*	451,956,091	

Source: A C Nielsen cited in the Hastings Report (see below) 2003

102 Appendix 34

Table 6: Children's after-school snack products, market size and advertising spend, 1998–2003

	Market size		*Adspend*	
	1998 £m	*2002* £m	*1998* £m	*2002* £m
Chocolate bars and countlines	3,745	3,494	68.9	91.0
Crisps and snacks	2,078	2,385	30.5	31.4
Sweets**	1,770	1,768	38.6	39.5
Sweet biscuits	1,484	1,462	7.2	16.3
Fresh fruit	2,962	3,150	4.5	2.8

** includes sugar confectionery and chewing gum

Source: Nielsen Media Research/Mintel

97. Figures from the Mintel study into advertising costs revealed that only a fraction of the amount of money spent advertising chocolate, sweets, crisps and snacks was devoted to advertising fruit. While a total of £178.2 million was spent in 2002 on advertising chocolate bars, crisps and snacks, sweets and sweet biscuits, over the same period only £2.8 million, less than 2% of this total, was spent on advertising fruit. Meanwhile, the £5 million annual budget of the Government's Five-a-day campaign is simply drowned out by the advertising budgets of large food companies.[103]

98. The food industry also deploys a full range of less explicit and visible, but no less effective, promotion techniques, such as inclusion within packs of collectible free gifts to encourage repeat purchase, and strategic placement of products within stores. Examples of this include placing high-sugar soft drinks in refrigerators alongside fruit juice, giving over a prominent end-of-aisle space to one product, or placing sweets near checkouts where they are guaranteed a captive audience of fractious children and hassled parents. In doing this, food manufacturers work closely with food retailers, in particular large supermarkets. While this relationship appears to work to the mutual benefit of both food manufacturers and retailers, the impact on the consumer may not be so positive. Packaging, pricing and the design of the products themselves are also used to encourage consumption. It is because product design is driven by consumer preference that so many children's food items are nutritionally poor. It was noticeable—and deeply regrettable—that when four food manufacturers (Pepsi/Walkers, McDonalds, Cadbury's and Kellogg) were giving evidence to us, only Kellogg gave a straight answer to the question "How much of your product would you advise a parent to give their five year old?" The other three representatives simply equivocated.[104] This points up the challenge facing parents when trying to help their children to eat healthily.

99. All these marketing efforts come together in evocative brands that have great emotional and psychological power. In a world increasingly dominated by such brands it is noticeable that the market leaders in the food industry—Coca Cola, McDonalds, Walkers—represent relatively unhealthy food options and are aimed heavily at children. However, the increasing availability of suitably healthy fruit and salad options at some fast food outlets is welcome if these are promoted energetically.

103 Department of Health press release, 5 October 2001

104 Qq 771, 774, 784, 786

100. While food advertising is an ever-present and accepted part of daily life, it is assumed that adults are sufficiently media-literate to be able to separate advertising claims from fact, to recognise the commercial motivation of advertising, to balance advertising messages against other relevant information, such as healthy eating messages, and to make their decisions accordingly. However, questions are now being raised about the legitimacy of explicitly targeting children, who may not be as able as adults to negotiate the pressure put on them by food advertising. According to the International Association of Consumer Food Organisations, children may be "technologically savvy" but they are "nutritionally inexperienced and ill-equipped to distinguish inflated sales messages from objective fact."[105] This is particularly concerning given that the promotion and advertising of unhealthy foods is targeted far more intensively at children than at adults: we were shocked to hear from research carried out by Sustain that during children's programming, adverts were screened between two and three times more frequently than during adult programming:

> Food advertisements were shown more frequently during children's programmes (45–58% of all advertisements) than during adult programming (21%).
>
> The overwhelming majority of the foods advertised during both adult (86%) and children's (**95–99%**) programmes were high in fat, sugar and/or salt.
>
> There were **no** adverts for fresh fruit and/or vegetables during either the adult or children's programmes.[106]

101. In addition the FSA commissioned a systematic review of the literature from a team of academics headed by Professor Gerard Hastings, at the University of Strathclyde (hereafter 'The Hastings Review'). This examined the academic literature on the amount and nature of food advertising to children over the last 30 years. It concluded that:

> children's food promotion is dominated by television advertising, and that the majority of this promotes pre-sugared breakfast cereals, confectionery, savoury snacks, soft drinks and, latterly, fast-food outlets.

102. It goes on to state that concerns should not be limited to television advertising and indeed that "There is some evidence that the dominance of television has begun to wane in recent years." The review suggests two reasons for this trend:

> First, the rise of new media (eg. computers, text-messages, internet and email) has given rise to a host of new potential creative strategies, in themselves more likely to be both accessed and understood by young people than their parents (compared to television). Secondly, the evolution of brand stretching and globalisation has allowed promotional messages to cut across many different media and increased tie-ins with below-the-line marketing activities. These may now include links to new media (eg. branded, perhaps online, computer games), other new promotional channels (eg. in-

105 International Association of Consumer Food Organisations, *Broadcasting Bad Health*, July 2003, p 8.

106 Parliamentary Office of Science and Technology, *Improving Children's Diet*, September 2003, p 45.

> school marketing) and more traditional avenues for below-the-line activities such as sports sponsorship.[107]

The review went on to conclude that:

> The advertised diet varies greatly from the recommended one, and that themes of fun and fantasy or taste, rather than health and nutrition, are used to promote this to children. Meanwhile, the recommended diet gets little promotional support.

103. It is not difficult to see why children are prime targets for food industry promotion and advertising—a report in *The Observer* cited a food industry publication arguing that for soft drinks companies, an eight-year old boy was the ideal target customer, as he had 65 years of consumption ahead of him.[108] Marketers also engage in what is known as 'cradle-to-grave' marketing which is essentially relationship marketing with children. In recognition of children's potential as consumers to a firm over their lifetime, promotion can be used to create and foster ongoing relationships with them. Usually strategies of this kind focus on branding in an effort to develop an emotional and enduring connection between the child and the brand. Academic research has shown the importance of brands to children of all ages; the relationships that children form with brands often become central components of their lives.[109] Promotion is used to encourage children to develop awareness of and preferences for a particular brand.

104. Advertising agencies and food manufacturers were quick to describe today's generation of children as "media-aware" and argued that they were perfectly able to recognise advertising for what it was and interpret it accordingly from as young as five years old.[110] However, Andrew Brown, Director General of the Advertising Association and also representing the Food Advertising Unit, admitted that children did not know the full persuasive influence of advertising until they were about eight or nine, and research suggests that children below the age of five years generally regarded advertising solely as entertainment.[111] Academic research confirms that there is real cause for concern about advertising to children. Understanding of its persuasive intent only emerges at 7–8 years.[112] Prior to this, children show very little ability accurately to judge and critically to reflect upon commercial messages, and as a result are very trusting of them. One study showed that 64.8% of 6–7 year old children reported "trusting all commercials".[113] At around the age of 8 years, there is evidence that children are *beginning* to respond to advertising in a more sophisticated and critical way.[114]

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107 Gerard Hastings et al, *Review of Research on the Effects of Food Promotion to Children*, Centre for Social Marketing, p 98

108 "The Junkfood Timebomb that threatens a generation", *The Observer*, 9 November 2003

109 M F Ji, "Children's relationships with brands: 'True Love' or 'One-Night Stand?", *Psychology and Marketing*, 19(4): 369-87; M Lindstrom, and P Seybold, *BRANDchild,* 2003

110 Q624

111 Parliamentary Office of Science and Technology, *Improving Children's Diet*, September 2003

112 D R John, "Through the eyes of a child: Children's Knowledge and Understanding of Advertising", in Macklin MC, Carlson L (eds), *Advertising to Children – Concepts and Controversies*, 1999

113 T S Robertson, J R Rossiter (1974), "Children and commercial persuasion: an attribution theory analysis", *Journal of Consumer Research*, 1974, pp 13-20

114 D R John, "Through the eyes of a child"

105. It is clear advertisers use their increasingly sophisticated knowledge of children's cognitive and social development, and careful consumer research into their motivations, values, preferences and interests, to ensure that their messages have maximum appeal.[115] Moreover, our inquiry showed that children as young as three years old are being deliberately targeted by UK food companies.

106. We used our powers to send for persons, papers and records to require the advertising agencies working for a number of popular fast food, carbonated drink, cereal and confectionery manufacturers to supply material to us. We requested the following information from Abbot Mead Vickers, concerning accounts for Pepsi-Cola and Walkers Wotsits, from Leo Burnett, concerning accounts for Kellogg's Cocopops and McDonald's, and from Coca-Cola directly: contact reports; client briefs; creative briefs; media briefs; media schedules; advertising budgets; market research reports; links to other communications; and links to marketing strategy.

107. The promotional material supplied by Leo Burnett for the McDonalds campaigns gave detailed information relating to 12 different campaigns for Happy Meals within a one-year period, targeted at different aged children, ranging from 3–11 years.[116] There is no nutritional information relating specifically to the calorific content of Happy Meals on the McDonald's UK website, but by adding the calorific content of different components, a Happy Meal with a cheeseburger and a regular coke can be shown to contain 613 calories, which could represent nearly half the daily caloric need of a six year old girl, and over half that of a three year old girl.[117] There were a total of **98** toys to collect over a period of one year—if a child were to collect all the toys they would require a Happy Meal every 3.7 days. One McDonald's campaign, Microstars, ran for a five-week period and had 20 toys to collect in the series. To collect all the characters free the child was required to average four Happy Meals per week during the promotional period, consuming 2,452 calories per week solely from Happy Meals, and a total of 12,260 calories over the five-week period. When questioned about this, Bruce Haines, for Leo Burnett, argued that toys were not designed to promote consumption, telling us that:

> the toys in a Happy Meal are considered by children to be an intrinsic part of the product, as is the packaging in which the food and toys are presented … the toys themselves are available for purchase in a McDonald's for about 99 pence in any case, so you do not actually have to eat the food to collect them. They are not free.[118]

108. However, this was directly contradicted by the creative and client briefs for some Happy Meal campaigns, which made it clear that an aim of some promotions was to "get children to believe 'I've got to have a Happy Meal so that I can have an X toy'."[119] We were also told by McDonald's that:

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115 H Stipp , "New ways to reach children", *American Demographics*, August 1993, pp 50-56.

116 Material relating to the various advertising campaigns cited in this report was submitted as "commercial in confidence" to the Committee. While we have quoted selected material from these campaigns, contained in an analysis produced by the Centre for Social Marketing, University of Strathclyde, at Appendix 61, we have agreed not otherwise to release commercially confidential material.

117 See Annex 3

118 Q592

119 Appendix 61

> The objective of the promotion is not principally to drive people to come in more often, it is largely designed to get different people to come in to our restaurants … our intention is of course to raise the frequency slightly, but it is very slightly.[120]

109. Again, this was directly contradicted by the client brief, which stated that there was "scope to increase frequency from light to heavy users."[121]

110. Manufacturers and advertising agencies told us that advertising food to children could never be argued to undermine healthy eating messages, as ultimately parents retained full control over what children ate as it was they who bought their children's foods.[122] However, recent research has shown children's own spending-power to be increasing considerably. The Mintel report on snacking noted a steep rise in the average amount of pocket money allocated to children between 1997–2001. On average, 5–16 year olds enjoyed a 45% increase in their pocket money over the period, such that the average amount of weekly pocket money was £6.53.[123] The authors of the report noted that "with an average of over £6 per week to spend on themselves, children can easily afford snack foods." Crisps and savoury snacks are the most popular after-school snack for children and "this form of savoury snack is within almost all children's budgets. Indeed a number of brands specifically target children and are competitively priced at 10p or 20p."[124]

111. Furthermore, the written evidence we requested from advertising agencies revealed that despite the Advertising Standards Authority (ASA) code banning this, many campaigns have pester power as an explicit aim: the Wotsits client brief had a specific aim of getting children to "pester their parents to buy them", and in the Media Strategy Brief the stated "desired consumer response" for the campaign was "Wotsits are for me—I'm going to buy them when I get a chance and pester Mum for them when she next goes shopping." Walkers, whilst acknowledging the inappropriateness of 'pester power' as an explicit aim of the campaign, sought to downplay its significance, and cited the fact that the campaign had been passed by the ASA.[125] However, **we were appalled that a £710,000 campaign, launched by one of Britain's largest snack manufacturers, deliberately deployed a tactic which explicitly sought to undermine parental control over children's nutrition by exploiting children's natural tendency to attempt to influence their parents. The fact that this campaign was approved by the Advertising Standards Authority does not exonerate it, but merely demonstrates the ineffectiveness of current ASA standards and procedures.**

112. The food industry's most frequently rehearsed argument in relation to the impact of advertising and promotion on the consumption of unhealthy foods, and hence its potential role in obesity, was that these tools simply increased the market share of a particular brand of food or drink, rather than expanding the total market by encouraging the consumption of a particular food group, such as chocolate or sweet fizzy drinks. Similar arguments have

120 Q770

121 Appendix 61

122 Q594, Q763

123 Mintel report, *After school snacking* (2002) p10

124 Ibid

125 Q859

been rehearsed by the tobacco industry, as we noted in our report into that industry.[126] However, the Secretary of State for Culture, Media and Sport was clearly able to see this argument for what it was:

> *Dr Naysmith*: I just wonder what do you believe on that when advertisers come and tell you, as they tell us, that all they are doing is trying to get a bigger share of the market for their brand when, in fact, what they are doing is trying to create a bigger market?
>
> *Tessa Jowell*: I suspect in practice it is a bit of both. What they are trying to do is to get you to buy Galaxy instead of Cadbury's milk or whatever it is, but they are also trying to increase overall levels of consumption, of course I understand that.[127]

113. As well as being an obvious commercial aim of those in the food industry, it is also clear from large-scale research that advertising of foods to children does have a marked effect on the category of foods they select as well as the brand. The Hastings Review, published in September 2003, provided the clearest evidence yet that advertising had a direct impact on the category of foods children selected, and increased consumption of unhealthy foods.[128] The food industry refused to accept the findings of this report, and commissioned its own report to rebut the findings of the Hastings Review and the large body of evidence on which they were based.[129] To resolve the issue, the FSA then commissioned an independent evaluation of the Hastings Review, which fully endorsed both its methods and conclusions.[130]

114. Advertising and promotion of foods to children is not limited to television, shops and restaurants, and we were surprised to learn of the full extent of food promotion now taking place in schools. Recent initiatives by Walkers and Cadbury's, which attempted to involve schools in promotion schemes by rewarding the purchase of crisps and chocolate with sports equipment for schools, were described by Susan Jebb as "an absolute Trojan horse", although both of these received full backing from Government ministers. [131]

115. According to Kath Dalmeny of the Food Commission, school breakfast clubs, originally conceived to ensure children received a healthy breakfast before school, are increasingly having to work in conjunction with the food industry:

> Some of the breakfast clubs have sponsored foods that are given out, because the school needs to find funding for the breakfast club, so particular manufacturers will sponsor them. I have seen Burger King sponsoring some of the breakfast clubs. While it might not mean that there will be Burger King foods being supplied necessarily to the schools, the fact that branded goods—which may be high in fat,

126 Health Committee, Second Report of Session 1999-2000, *The Tobacco Industry and the Health Risks of Smoking*, HC 27 para 89

127 Q1424

128 Gerard Hastings et al, *Review of Research on the Effects of Food Promotion to Children, prepared for the Food Standards Agency – Final Report*, Centre for Social Marketing, 22 September 2003.

129 www.fau.org.uk/content/pops/brian_youngliteraturereview.pdf

130 Professor Stan Paliwoda and Ian Cranford, An analysis of the Hastings Review, "The effects of food promotion on children", December 2003, www.food.gov.uk

131 Q313

> high in sugar, high in calories—are associated with those healthy eating schemes and associated with the endorsement of the school is problematic, I think, because it gives the message to children that these are good options to choose, that they are a regular part of their lives.[132]

116. An increasing number of schools also provide schoolchildren with access to unhealthy foods through vending machines installed in school premises. Schools are in many respects a 'captive market' for the food industry, as often vending machines represent the only opportunity schoolchildren have to purchase drinks and snacks during the school day. The motivation for schools to install vending machines is clear, as in total they contribute over £10 million each year to school budgets.[133] However, the impact on children's nutrition and health may be less positive. A pilot study funded by the FSA and carried out in 12 secondary schools has recently concluded that when given the option, children do make healthy choices. The 12 schools all installed vending machines containing healthier drinks, such as milk, water and fruit juice, and approximately 70,000 healthier drinks were bought during the 24-week duration of the trial.[134]

117. Supplying healthy meals at school not only provides an opportunity to influence a young person's nutritional and calorific intake in a positive way, but can also encourage young people to try new, healthy food they might not otherwise have access to, and shape their eating habits outside school. However, our evidence suggests that, far from doing this, school catering arrangements allow children to eat very unhealthily. The prevalence of cafeteria-style food outlets that allow pupils to opt out of healthy choices in favour of unhealthy ones remains high in schools, and a report by the Consumers' Association argued that the majority of school lunch menus "read like fast food menus"[135]. This is in stark contrast to the school lunch we sampled in Finland, where children were given no other option but a filling, healthy lunch, which included a portion of salad but no pudding, with the choice of beverage limited to water or milk. This confirms the findings of one of the key studies uncovered in the Hastings Review which showed that vending machines in school could be used to encourage the consumption of healthier food options with appropriate signage, pricing and offerings.[136]

118. With much school food provision now contracted out to independent suppliers, the onus appears to be on delivering palatable foods as cheaply as possible, with little recourse to health benefits. Sustain reported that some schools have available as little as 40p per child to provide the ingredients for a two course lunch.[137] The Welsh Food Alliance argued that according to one large commercial catering contractor, English public schools spend twice as much as the state sector on food ingredients for school lunches.[138]

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132 Q380

133 Schools may receive an income of £10–15,000 per annum. See www.laca.co.uk.

134 http://www.food.gov.uk/multimedia/pdfs/vendingreport.pdf

135 Ev 391

136 S A French et al, "Pricing and promotion effects on low-fat vending snack purchases: The CHIPS Study", *American Journal of Public Health*, Vol 91, 1 (2001), pp 112-17

137 Ev 109

138 Appendix 38

119. Food labelling, detailing the calorific and nutritional content of foods, is a key element of the information people need to make healthy choices, and inadequate labelling can have a negative impact on nutrition in several ways. First, if nutritional information is absent, unclear or misleading, this could encourage the purchase of a product which a consumer would not buy if it were clearly labelled as high in fat or calories. An example frequently cited in our evidence was that of products claiming to be 'light' options when in fact they were still high in calories, and products claiming to be '70% fat free', putting the onus on consumers to notice that that this actually meant the product was 30% fat, and would in fact be termed by the FSA as containing a lot of fat.[139] Health claims may also be made on high calorie products to promote purchase, for example claims that breakfast cereals boost concentration and healthy bones, when the same health benefits could be accrued from products with a far lower calorie content.

120. Currently, nutritional labelling in England is largely voluntary. Not only does this mean that on some foods nutritional labelling can be entirely absent, but even when food is labelled, there is little consistency about the format or size of labelling, making it difficult to interpret or even to see. Some products give information per 100g, and some per packet, which is less useful for a consumer than the same information presented by serving. Even when products do give nutritional information by serving, the size of a 'portion' may vary between brands.

121. While there are many problems and inconsistencies about nutritional labelling on pre-packed food, information about the nutritional content of food purchased in restaurants or take-aways is virtually non-existent, and since this is now the fastest growing food sector, this problem is set to increase.

122. Despite the barrage of information consumers receive about food, whether through labelling, advertising, promotion, or health education, price remains a key determinant in choice, with research suggesting that cheap food is the priority for consumers using supermarkets. While 'healthy' versions of foods are becoming increasingly available, and consumers are seemingly very willing to buy them (research by the Consumers' Association suggested that 38% of shoppers claimed they would be willing to pay a little extra for foods carrying a 'healthy' logo[140]), instead of fostering this desire to eat healthily, the food industry appears to be exploiting it by selling foods with reduced fat or calories at considerably elevated prices. A recent survey by the Food Commission, illustrated that a shopping basket of 'healthier options' was 51% more expensive than a basket of standard processed foods. In April 2003, an article in *Health Which?* on supermarket healthy eating ranges, such as 'Good for You', 'Be Good to Yourself' and 'Eat Smart'[141] identified that in some cases there could be up to 200% price difference between the healthy and standard versions. In addition to this, they argued that many of the healthy options offered very little or no calorie saving, with some simply containing a smaller serving of the identical product.

123. Price differentials are likely to be even greater when healthy versions are compared to supermarkets' 'budget' lines. Most supermarkets do not offer healthy alternatives within

139 www.food.gov.uk

140 *Health Which?* , April 2003

141 *Health Which?*, April 2003

their own budget brands aimed at people shopping on a smaller budget. In a recent survey in the *Sunday Herald* ASDA was the only supermarket of the 'Big Five' which offered low-fat alternatives within its economy range, although it admitted that the items had "not consciously been developed as low fat".[142] In fact, research carried out by the Consumers' Association in February 2002 suggested that on average budget brand crisps had more fat, calories and saturated fat than standard versions.[143]

124. Naturally healthy foods such as fresh fruit and vegetables are also considerably more expensive than non-healthy alternatives. Comparing the prices of various fruits with high calorie snacks certainly demonstrates pricing differences. On the Tesco online shopping website, bananas are priced at approximately 13p each, with apples varying in price between 17–34p each. 'Funsize' small pears, marketed at children, cost 18p each, and satsumas are more expensive at 21p each. By contrast, small chocolate bars, some marketed specifically at children as 'breaktime' size, varied in price between 8p for a Milky Way to 16p for a Snickers. Crisps were even cheaper. Tesco's own brand crisps cost just 5p per bag for the budget range, or 8p per bag for the standard range, with Walkers branded crisps available at 11p per bag.

125. While many supermarkets claimed to support Government initiatives to promote fruit and vegetables to children, according to research carried out by Friends of the Earth pre-prepared fruit and vegetables packaged to appeal to children were being sold at vastly inflated prices by several of them. For example, Tesco's Kids Snack Pack carrots cost £5.50 per kg, 13 times the price of Tesco's 'value' carrots, while ASDA's 'Snack pack carrot crunchies' cost 10 times the price of normal carrots.[144]

126. An important form of price promotion is the phenomenon of 'super-sizing', where food is sold in larger quantities or portion sizes at little extra cost. Super-sizing is now visible everywhere from fast-food outlets, where it originated, to supermarkets. Although McDonalds have now withdrawn the largest of their super-size sizes, Julian Hilton-Johnson confirmed in evidence to us that all McDonald's staff are trained to promote super-size portions verbally when serving customers.[145] According to Professor Andrew Prentice, the falling cost of foods has directly contributed to super-sizing, as it is now very easy to use "bigger is better"[146] as a marketing tool. Susan Jebb, as a dietician, felt that super-sized portions were entirely superfluous to the energy needs of a normal person, arguing that "there is almost nobody in the UK who needs super-size portions, our energy needs are lower than ever."[147]

127. The evolution of super-size food portions began with the introduction of the McDonald's Big Mac in 1968 and accelerated in the 1970s with value meals, special packaging, promotional campaigns, and lower prices.[148] McDonald's Corporation

142 Mona McAlinden, "Supermarkets fail to cut fat in 'value' brands", *Sunday Herald*, 23 November 2003 (based on a survey of the five leading supermarket chains in the UK: ASDA, Safeway, Somerfield, Sainsbury's and Tesco).

143 "Do supermarkets' budget lines mean shrewd shopping or are they just a false economy?", *Health Which?*, February 2002,

144 Friends of the Earth, press release 8 November 2003, www.foe.co.uk

145 Qq 836-38

146 Q369

147 Q368

148 "The Gorge-Yourself Environment", *NY Times*, 22 July 2003

executive David Wallerstein initiated the super-size hamburgers, french fries and colas in the 1970s, taking his lead from the cinema industry, where high mark-up of jumbo-sized snacks like popcorn and cola led to higher profits.[149]

128. Food companies in the USA have been able to cut prices and spend more money on innovating new and larger food products because of the drop in prices for sugar, soybean, corn, palm oil, meat and other commodities. When food price inflation reached an all-time high in the early 1970s, consumer groups mobilised and agricultural policies were reformulated to ease regulation and increase production.[150] The price of sugar fell with the discovery of a way economically to produce a cheaper sweetener called high-fructose corn syrup (HFCS) in 1971. This invention ended years of unnaturally high sugar prices due to foreign aid policies. HFCS was six times sweeter than cane sugar and could be made from corn so the cost of production was much lower, allowing companies to produce more food for equal or less cost. Low price led both Coca-Cola and Pepsi to switch from a 50–50 blend of sugar and corn syrup to 100% HFCS, saving both companies 20% in sweetener costs.[151] From the mid–1970s American trade policies also ensured low prices for palm oil. By the early eighties the price of every single commodity was down. Meat production worldwide soared as feed costs of soy meal and corn fell. Calorie-dense foods at supermarkets were more affordable due to growing surpluses of US corn producing more HFCS.[152]

129. So why are healthy foods so expensive, while unhealthy foods are sold so cheaply by comparison? Much of our evidence implicated the European Union Common Agricultural Policy (CAP), through its subsidies for withdrawal and destruction of good quality fruit and vegetables to maintain prices, consumption aid for butter, consumption aid for high-fat milk products in schools, and subsidies to promote sales of high-fat milk products and wine.[153] According to Tim Lobstein of the Food Commission:

> Food supply is a lot of the push towards why our diets have been shifting over the last few years. The surplus amounts of sugar and butter and vegetable oils, which have been created under the Common Agricultural Policy, have to find a home somewhere. Surplus foods are disposed of and destroyed but the extra fats and oils all go into our food supplies.[154]

130. The problems with the CAP stem from the basic provisions of the original Treaty of Rome, which put the focus on trade and economic issues, with little or no concern for public health. This has to change if Britain's health is to improve.

131. Professor Marion Nestle, from the Department of Nutrition, Food Studies and Public Health, New York University, in compelling evidence to us, argued that food overproduction was the root cause of obesity in the United States, which currently

149 Greg Critser, *Fat Land : How Americans Became the Fattest People in the World*, 2003.

150 Ibid

151 Ibid

152 Ibid

153 For example, Alan Maryon Davies, Q567.

154 Q358

produces approximately 3,900 calories of food per day for every man, woman and child in the country, roughly double the average calorific need.[155]

132. While we have not had the scope or expertise, during the course of this inquiry, fully to explore the agricultural and economic policies behind food pricing in the UK, it is apparent that the current situation does very little to facilitate consumers making healthier nutritional choices.

Causes of obesity related to physical inactivity

133. There is little doubt that the nation as a whole is not as active as it should be. Current Department of Health advice is for individuals to undertake at least 30 minutes of moderately intensive activity (e.g. brisk walking) on at least 5 days a week. However, only around 37% of men and 25% of women currently achieve this target.[156] Levels of activity in the UK are below the European average which is part of the explanation for higher obesity rates.[157] For children and young people, the Department of Health advice is that they should undertake one hour of moderate activity each day. The Chief Medical Officer's recent report into the impact of physical activity and its relationship to health "confirms that, according to the best evidence, these recommendations remain appropriate for general health benefits across a wide range of diseases."[158]

134. *Game Plan*, the strategy for delivering the Government's sports and physical activity objectives, jointly produced by the Department for Culture, Media and Sport and the Cabinet Office Strategy Unit in December 2002 estimated the cost of physical inactivity in England at around £2 billion per year, a figure roughly equivalent to the £2.2 billion spent at that time by Government and lottery sources on sport. Each 10% increase in activity across the population has a potential gain of £500 million.[159]

Changing lifestyles

135. The NAO report *Tackling Obesity in England* stated that the extra physical activity involved in daily living 50 years ago, compared with today was the equivalent to running a marathon a week.[160] So why have lifestyles changed so dramatically in the past 50 years? A first answer lies in the increasing use of motorised transport instead of active methods of transport, such as walking and cycling. The latest National Travel Survey indicates that the average person now walks 189 miles per year, a fall of 66 miles over 25 years.[161] According to Tom Franklin, of Living Streets, it is clear that "we are walking less than we have probably ever done in history."[162] Mr Franklin attributed the decline in walking to the loss

155 Q461

156 Health Survey for England

157 Ev 118 (National Heart Forum)

158 Department of Health, Chief Medical Officer, *At least five a week: Evidence on the impact of physical activity and its relationship to health*, 2004, p 2

159 Ev 163 (Living Streets), *Game Plan: A Strategy for Delivering Government's sport and physical activity objectives*, p 47

160 NAO, *Tackling Obesity in England*, 2001, p 13

161 Ev 163

162 Q 489

of opportunities to walk, as well as to increased access to motorised transport. He argued that people would not walk to local services, be they schools, hospitals, GP surgeries or shops, that were sited more than 15 minutes' walk away, and moreover that increasingly services such as these were covering larger areas and so moving further away from residential centres.[163]

136. Measuring how active people are is difficult. The traditional approach has been to rely on questionnaires but such self-reporting is unreliable. As Chris Riddoch, an expert in physical activity based at Middlesex University, told us:

> People will report what they remember doing. They tend to remember the things they plan to do. If they went for a walk with the dog they will remember that. What they do not remember are all the incidental things they do like nipping up the stairs to the office on the floor above. Self-report measures have a fairly large amount of error built in to them.[164]
>
> A more effective measurement is achieved by the use of pedometers which record the actual number of steps taken each day.[165]

137. The increasing use of cars has led to a vicious circle of car dependency, as town planning has increasingly prioritised the needs of motorists above those of pedestrians and cyclists, meaning that in many places walking and cycling are at best unpleasant and at worst dangerous. At the same time, local neighbourhoods are increasingly perceived by parents as unsafe for children to play out in, implicitly discouraging active play and forcing children back in front of the television set. This phenomenon was repeatedly described by our witnesses.

138. England now reflects the result of two generations of planning centred on the use of cars. Car parks are readily available, but bike racks are not. Employees who want to walk or cycle to work frequently have no place to get showered and changed when they arrive at the workplace.

139. Tom Franklin suggested to us that the conditions for the pedestrian had actually deteriorated over the last half century: "The focus of people who are managing our streets has been about moving the traffic as fast and efficiently as possible and pedestrians have been shoved to one side."[166] John Grimshaw for Sustrans noted that the Highway Code stated that motorists should give way to pedestrians at junctions but that "no pedestrian who is alive has ever obeyed that rule."[167]

140. Pedestrians and cyclists are the 'second class citizens' of Britain's roads:

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163 Ibid

164 Q 490

165 Pedometers are instruments attached to a person's waist which measure the number of steps taken. Some models will translate these into numbers of kilometres or miles walked and also calculate calories used in walking. The cheapest pedometers cost under £10.

166 Q496

167 Q499

> What you find is that people walking are sent underground, they are sent over bridges, they find railings at the side of the pavement so they cannot cross where they want to cross.[168]

141. The Environment, Transport and Regional Affairs Committee (whose remit is now covered by the Office of the Deputy Prime Minister), in 2001 undertook a major inquiry into walking in towns and cities, in which they argued:

> In contrast to the changes made to every town and city to ease motor transport, walking has been made ever more unpleasant. Pedestrians have been treated with contempt. We are corralled behind long lengths of guard railing, forced into dark and dangerous subways and made to endure long waits at pedestrian crossings … The short walk to the shops has been made unpleasant so that the commuter can get to the centre of town more quickly.[169]

142. Dr Nick Wareham of the Institute of Public Health, University of Cambridge, graphically illustrated the decline in cycling when he pointed out that 23 billion kilometres were cycled in the UK in 1952 but only 4 billion kilometres were now cycled annually.[170] The decline in cycling has occurred at the same time as the UK car population has grown in size. Whereas there were 16 million cars in 1975 there are 27 million today.[171]

143. Cycle use in European countries such as the Netherlands differs from Britain where cycling drops off markedly in the mid-teenage years, particularly for women, whereas Dutch men and women maintain healthy cycle use into adulthood and old age. CTC, the national cyclists' association, suggested that cycle training was a key component in maintaining use.[172]

144. Less tangible, but probably at least as pertinent, has been the reduction in physical activity in everyday life arising from mechanised tools, warmer dwellings, labour-saving devices, lifts and escalators, more sedentary jobs, and the pursuit of more sedentary leisure activities. Only 20% of men and 10% of women are employed in active occupations. Television viewing has doubled since the 1960s, when the average person watched television 13 hours a week compared to 26 hours now.[173]

Children's activity levels

145. The Chief Medical Officer's recent report into physical activity suggested that 2 in 10 boys and girls undertake less than 30 minutes activity a day.[174] Once again, changes in lifestyle must bear much of the blame for the levels of activity of young people.

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168 Q560 (Tom Franklin)

169 Environment, Transport and Regional Affairs Committee, Eleventh Report of Session 2000-2001, *Walking in Towns and Cities*, HC 167 para 4

170 Q339

171 www.racfoundation.org; www.dft.gov.uk

172 Appendix 8

173 Appendix 18 (Royal College of General Practitioners)

174 *At least five a week*, p 9

146. According to the organisation Working for Cycling, in 1985–86 only 22% of 5–10 year olds were driven to school; that figure had risen to 39% by 1999–2000. Paul Osborne of the National Heart Forum noted that fewer than 1% of school journeys were made on bicycles in this country. That compares to about 15–20% in Germany and 50% in Denmark.[175] This may be because at least one-third of primary schools have effectively banned cycling to school by refusing to allow children to bring bicycles onto the premises.[176]

147. As Tom Franklin for Living Streets pointed out, the impact of lowered physical activity will not fall simply on the health of the present generation of schoolchildren, but will be carried into adulthood and will be perpetuated when today's children become parents themselves:

> For the first time ever less than half of our young children are walking to school. They have learned habits which they will take with them through the rest of their life which is that you drive round the corner rather than walk round the corner.[177]

148. Once at school, children struggle to meet the Government's target of two hours of PE per week. A national survey by Sport England indicates that Government guidelines on sport in schools have had mixed results. The survey showed that the percentage of children who do not take part in any sport at school on a regular basis had increased from 15% in 1994 to 18% in 2002. On the other hand, the percentage of children receiving two hours or more of PE a week increased from 33% in 1999 to 49% in 2002 (although the rate of increase seems to be slowing, with a rise of only three percentage points since 1994).[178] This last result is positive in that it shows the amount of PE in schools does seem to be increasing, although it remains a fact that one in two children does not receive at least two hours of PE in the curriculum. The Government aim therefore remains aspirational.

149. Our predecessor Committee, in its report into *Public Health* in 2001, noted that in many European countries, such as Austria, Norway, Portugal, Spain and Switzerland, an average of 3.5 hours per week was spent on school sport.[179] The European Heart Network has recommended a statutory minimum three hours per week dedicated to physical activity for all ages of young people.[180]

150. Activity levels appear to have fallen in every aspect of children's lives. Len Almond, from the British Heart Foundation National Centre for Physical Activity and Health, pointed to a "substantial decrease" in children's activity levels during school break-times, telling us that some schools had even put seats in playground so that children could sit down for the whole of the lunch break. There has also been a major reduction in active play at home, with children engaged in far less activity at weekends than they are between Monday and Friday. According to Professor Almond, active play:

175 Q388

176 Q396

177 Q476

178 Appendix 19 (Sport England)

179 Health Committee, Second Report of Session 2000-01, *Public Health*, HC 30, para 191

180 European Heart Network, *Children and Young People – the Importance of Physical Activity,* December 2001, p19

is simply being completely eroded (1) through lack of opportunities to play and (2) through the fact that there is no repertoire of games or activities that children can play … They have no repertoire of games or activities to play because they have lost it all, it has been lost over a number of years, and as a consequence boredom—"I'm bored"—is very often a thing that young people complain to their parents at school holidays and weekends.[181]

181 Q400

3 Solutions

151. In an article covering an interview with Melanie Johnson MP, Minister for Public Health, in November 2003, the *Health Service Journal* called her attitude towards the obesity issue "surprisingly sanguine" and "remarkably relaxed". The Minister described Government action on obesity as follows:

> We are doing a lot of things on obesity already—we have a food and health action plan under way. We have the Five-a-day programme, the schools fruit scheme. I'm not sure you need a strategy because we are talking about some very simple messages—take a bit more exercise, eat a bit better, make sure your children do the same.[182]

152. In direct contrast to this, obesity experts from whom we received oral evidence repeatedly stressed the complexity of the problem of obesity, and the naïvety of approaching it in such a simplistic way. Dr Susan Jebb told us "one of my key points is there is no one simple solution. If there was, we would have done it by now."[183] Professor Jane Wardle, of the Health Behaviour Unit at University College London, argued that as "it has been multiple small changes in society which have contributed to the changing population weights", "we are going to have to intervene in multiple ways to push it back down again, there is not one simple answer."[184]

153. **The causes of obesity are diverse, complex, and, in the main, underpinned by what are now entrenched societal norms. They are problems for which, as our expert witnesses have emphasised, no one simple solution exists. However, to fail to address this problem would be to condemn future generations, for the first time in over a century, to shorter life expectancies than their parents. A recent report by the Royal College of Physicians, Royal College of Paediatrics and Child Health, and the Faculty of Public Health emphasised the need for solutions to be "long term and sustainable, recognising that behaviour change is complex, difficult and takes time."[185] We believe that an integrated and wide-ranging programme of solutions must be adopted as a matter of urgency, and that the Government must show itself prepared to invest in the health of future generations by supporting measures which do not promise overnight results, but which constitute a consistent, effective and defined strategy.**

154. Recent months have seen commentators remarking with increasing frequency on the need to transform the current provision of healthcare in this country from a national illness service to a true national health service, and a White Paper positioning public health as a central plank of this Government's health policy is expected later this year. Although it may not currently be delivering all it could in terms of preventative medicine, many of our witnesses explicitly stated that this country's primary care based health service puts the UK

182 *Health Service Journal*, 6 November 2003, pp 26-27

183 Q315

184 Q256

185 *Storing up problems*, p xii

in a uniquely strong position to tackle obesity as a public health problem. We consider NHS provision for both prevention and treatment of obesity later in this chapter. However, **while the NHS is clearly central to tackling obesity through providing specialist health promotion and treatment for people who are already obese, we believe that the most important and dramatic changes will have to take place outside the doctor's surgery, in the wider environment in which people live their lives. And while we recognise that individuals have a key role to play in determining their own health and lifestyles, as the main factors contributing to the rapid rises in obesity seen in recent years are societal, it is critical that obesity is tackled first and foremost at a societal rather than an individual level.**

155. In his recent report *Securing Good Health for the Whole Population* Derek Wanless remarked:

> Evidence-based principles still need to be established for public health expenditure decisions. Although there is often evidence on the scientific justification for action, there is generally little evidence about the cost-effectiveness of public health and preventive policies or their practical implementation.[186]

We acknowledge that this is the case. Clearly, it is not within our resources to attempt to cost the solutions we propose in this chapter; that is a matter for Government. We are however encouraged by Mr Wanless's own observation on the need for taking action even in the absence of a comprehensive evidence base:

> The need for action is too pressing for the lack of a comprehensive evidence base to be used as an excuse for inertia. Instead, current public health policy and practice, which includes a multitude of promising initiatives, should be evaluated as a series of natural experiments.[187]

156. Obesity is a perfect example of an issue that demands truly joined-up government action, with the work of at least six separate government departments directly impacting on it. As well as the Department of Health, which retains lead responsibility for obesity as a public health issue, the Department for Culture, Media and Sport has policy responsibility for promoting sport and physical activity, and also for the media, including the advertising of foods. The Department for Education and Skills has responsibility for ensuring children receive adequate physical education at school, as well as responsibility for the food children have access to in school, and for children's education about nutrition and food preparation. The Department for Transport has responsibility for ensuring that transport policies support healthy transport such as cycling and walking; the Office of the Deputy Prime Minister has responsibility for promoting urban spaces in which people can pursue healthy travel and recreational activities; the Department for Environment, Food and Rural Affairs has an influence through its remit for farming and food production; and the Department of Trade and Industry has a stake in this debate through its responsibility for the food manufacturing and retail industries. The Department for Work and Pensions could also be influential, in that it oversees this country's increasingly sedentary working lifestyles. The

186 Derek Wanless, *Securing Good Health for the Population*, Final Report, February 2004, p 5

187 Ibid, p 121

list might be further widened were we to include other areas of Government on which obesity, if left to accelerate unchecked, is likely to have an impact in future years.

157. However, despite reassurances from Ministers, our evidence does not suggest that the Government is yet considering obesity in such broad terms, or even that those parts of government with a more obvious and immediate stake in the obesity issue have been working together successfully. Although Imogen Sharpe, Head of Cardiovascular Disease and Cancer Prevention at the Department of Health, told us about no fewer than seven separate boards, initiatives and meetings taking place across the Government to consider issues which might have an impact on obesity, in none of these did the issues of physical activity and diet appear to be linked together. Two Government Ministers from different departments have so far lent their approval to food marketing schemes aimed at children, whereby children are encouraged to purchase and consume high-fat foods, such as chocolate and crisps, in exchange for contributions towards school sports equipment. The Food Commission has calculated that "in order to obtain a 'free' basketball worth around £10, some £71 would need to be spent on 170 chocolate bars. A child would have to play basketball for 90 hours to expend the 40,000 calories and 2kg of fat from that amount of chocolate."[188] These initiatives were robustly condemned by the FSA, and we learnt that neither they nor the Department of Health were consulted prior to these schemes receiving ministerial endorsement, starkly revealing the contradictions that have arisen within policy concerning obesity.[189] Tim Lobstein, of the Food Commission, expressed extreme frustration with this:

> I think top of your list is going to have to be a recommendation that governments bang each other's heads together, that is to say you need a cross-departmental nutrition and physical activity policy. I talked to Tessa Jowell quite recently and she could only see the sports side of her department and would not listen to any discussion about the media side, which is advertising.[190]

158. We were very surprised that when we sought oral evidence from officials from DEFRA to discuss aspects of food production policy and its potential impact on obesity we were repeatedly rebuffed by that Department, who maintained that they had no part to play in discussions concerning obesity. Eventually, after intervention by the Secretary of State, a witness from DEFRA did appear before the Committee, but through no fault of his own had not been briefed to talk about those issues we considered most central to his Department's influence on obesity, and had no responsibility in respect of the Common Agricultural Policy. We were later supplied with written information on the Common Agricultural Policy by the Secretary of State, which is discussed below.

159. **We feel strongly that the problem of obesity needs to be recognised and tackled at the highest levels across government. We therefore recommend that a specific Cabinet public health committee is appointed, chaired by the Secretary of State for Health, and that one of its first tasks is to oversee the development of Public Service Agreement (PSA) targets relating to public health in general and obesity in particular, across all relevant government departments.**

188 Ev 109

189 Q14

190 Q357

160. Experience in Scandinavia and in other countries where dietary change was needed has shown the value of having a public health co-ordinating council or other body which operates in the public domain and maintains the drive for cross-governmental action. It can also provide a regular overview of the determinants of diet and physical activity and the effectiveness of interventions. To that end, **we recommend that the Government should consider either expanding the role of an existing body or bodies, such as the Food Standards Agency or Central Council of Physical Recreation (or linking these), or consider the creation of a new Council of Nutrition and Physical Activity to improve co-ordination and inject independent thinking into strategy.**

Nutritional solutions

161. The previous chapter discussed the causes of obesity at length. Although the debate about whether nutritional changes or physical activity changes have been the main driver of the increases in obesity is still ongoing, it is clear that to tackle obesity effectively, whether through the treatment of existing obesity or prevention of future obesity, solutions need to be found that will address both sides of society's changing energy balance: that is to say to reduce the intake of calories through altering nutritional intake, and to increase energy expenditure through changing physical activity habits.

162. As we have noted, energy intake at the beginning of the twenty-first century is very different from that of 50 years ago. While people in Britain may technically be consuming fewer calories, they are overeating in relation to their energy needs, are eating far greater proportions of fats and are having their normal appetite control overridden by the increasing availability of highly energy-dense foods and soft drinks. At the same time lifestyles have changed dramatically, meaning that people rely heavily on convenience foods. The British consume the highest number of ready meals in Europe; snacking is up; eating out is up. These trends, driven by far reaching societal changes, are not ones that it would be possible or even necessarily desirable to attempt to reverse. But there are certain tools today's population need if they are to be able successfully to negotiate what several witnesses have termed an increasingly 'obesogenic' environment.[191]

Information and choice

163. Altering people's dietary habits would appear to be an obvious and simple starting point in tackling obesity, and in their evidence, the Department put considerable emphasis on their actions to date in addressing the nutrition side of the obesity equation. They cited ongoing work on a Food and Health Action Plan, which was announced in December 2002 as part of the Government's strategy for Sustainable Farming and Food, although no date has been set for publication. The Department also drew attention to the National School Fruit Scheme, and the Five-a-day health promotion programme, both of which aim to increase consumption of fruit and vegetables.

164. However, it is clear that, as solutions to the obesity epidemic, the fruit and vegetable promotion schemes favoured by the Government have significant limitations. First, although the consumption of five portions of fresh fruit or vegetables a day is accepted as

191 Q294

being beneficial in its own right, it is difficult to see precisely how this will help tackle obesity, unless it is assumed that consuming more fruit and vegetables will displace calories from other sources. The Government's fruit and vegetable campaigns only stress the importance of consuming fruit and vegetables—they make no suggestion that these should be consumed as snacks instead of, for example, chocolate or crisps. The same holds true for the Free School Fruit scheme, which is currently only being made available to very young children aged between four and six.

165. The Government has recently invested £7.5 million on an advertising campaign aimed at stopping people smoking. By contrast, although we were told by the Public Health Minister that obesity commanded the same priority as smoking,[192] there have to date been no public health education campaigns directly aimed at reducing obesity through nutritional changes, or by any other means.

166. Research suggests that the recent anti-smoking advertising campaign has already had a small, but significant impact.[193] It is interesting to note that this campaign has relied heavily on shock tactics, employing unashamedly graphic depictions of arterial fat accumulation caused by smoking. While smoking and nutrition have obvious differences, this suggests that negative messages are capable of generating a powerful impact.

167. While we strongly endorse the Government's efforts to reduce smoking, it seems odd that so much sustained effort and investment has been put into this while no steps at all have been taken to tackle obesity, despite its occupying, according to the Public Health Minister, joint top priority with smoking. Indeed, the Government has also invested substantially in other health education campaigns on issues which, although clearly important, have not been identified by Government as a top public health priority, during the time that obesity has received none. For example, £40 million has been targeted towards reducing teenage pregnancy between 2003–06, and £4 million spent on a sexual health education campaign over two years.[194]

168. We in no way wish to imply that any of these areas of public health are undeserving of the attention and funding that the Government has invested in them. Indeed, our own recent inquiry into *Sexual Health* identified this as a very important and neglected area of public health.[195] However, what it does seem to suggest is that the Government's approach to public health education over the past few years has been responsive rather than pro-active, and has not been informed by any kind of sustained strategic prioritisation.

169. In his recent report into public health, Derek Wanless argued convincingly that since the demise of the Health Education Authority (HEA), no single body has held strategic responsibility for public health education campaigns. When we put this to the Public Health Minister she told us that the Health Development Agency was carrying on the HEA's work successfully. However, we received no evidence at all from the Health Development Agency for this inquiry into a major public health issue, a fact that we feel speaks for itself. **We strongly endorse the Wanless Report's recommendation that the**

192 Q1304; Q1306

193 http://news.bbc.co.uk/1/hi/health/3579313.stm

194 Department of Health, press release 2002/0499, 28 November 2002

195 Health Committee, Third Report of Session 2002–03, *Sexual Health*, HC 69

Government must assign clear responsibility for the health educational role, previously played by the Health Education Authority, a fact made clear in correspondence from the Department to the Committee.[196]

170. **We were very surprised that despite its occupying 'joint top priority' on the Government's public health agenda, there have been no health education campaigns aimed at tackling obesity. Although we acknowledge its benefits, we do not accept the Government's view that the Five-a-day fruit and vegetable promotion campaign is either designed for, or capable of, addressing the nutritional aspects of obesity. In recent years the Government has funded health education campaigns around, amongst other things, smoking, teenage pregnancy and sexually transmitted infections. The order in which other public health issues have been addressed, and the exclusion to date of obesity from this list, make the Government's actions in this area appear haphazard rather than strategic.**

171. **If the Government intends seriously to address obesity through health promotion, it must adopt a health education campaign dedicated exclusively to tackling obesity, which should follow the model used in the recent anti-smoking campaign, plainly spelling out the health risks associated with being overweight or obese, and also highlighting those nutritional and lifestyle patterns which are most conducive to weight gain. It should specifically identify 'high risk' foods and drinks, and should also emphasise the fact that consuming alcoholic drinks, like any other high-calorie food or drink, can also be conducive to unhealthy weight gain. At the same time, it should highlight the importance of physical activity both in preventing obesity and reducing weight levels. Part of the campaign should emphasise the crucial links between obesity and diabetes, and between obesity and cancer (which we have heard is barely known by the public as a whole). We recommend that such a health promotion campaign should be launched as soon as possible, with the Food Standards Agency advising on the nutritional content of such promotion, and the Activity Co-ordination Team, if this remains operational, or alternatively Sport England through its links with Move4Health**[197] **advising on the physical activity dimension.**

172. An awareness of the importance of healthy eating is useless without the practical skills to translate this knowledge into action. As well as understanding what constitutes a balanced diet, people need to know how to identify healthy foods and how to prepare them healthily, in order to reverse the increasing reliance on ready-prepared meals which require minimal cooking skills. We have heard evidence that cookery teaching has been progressively eroded by pressure to focus on other areas of the curriculum, and that, where food technology is taught, practical lessons have largely been replaced by theoretical learning about food manufacturing and marketing.[198] For many schools the only source of practical cooking lessons is through voluntarily provided initiatives such as cooking buses. The Rt Hon Margaret Hodge MP, the Minister for Children, argued that provision of food education was now better than ever:

196 Department of Health, Memorandum OB 8C (*not printed*)

197 Move4Health is a co-ordinating body representing interested parties seeking to tackle physical inactivity. More information can be found at www.Move4Health.org.uk.

198 Appendix 34 (Focus on Food)

> In our days we were not really taught about the ingredients and the nutritional content, or otherwise, in any great detail or the impact on our health. That link between being able to cook and linking it back into the healthiness of the ingredients you choose to cook is much stronger today than it was in the past, in some ways it is better than it was.[199]

173. Mrs Hodge also felt that food education was widely available: "food technology, as it is known today, is on universal offer in every primary school and it is available in 90% of our secondary schools."[200] However, although she told us that 100,000 students take GCSE food technology per year, this only represents approximately 16% of GCSE students.[201]

174. **Understanding the importance of healthy eating is meaningless without the skills to put these messages into practice. The huge demand for initiatives such as the Focus on Food Cooking Bus is a testimony to the extremely limited opportunities for cooking and food training within schools, and also to the desire of both pupils and teachers to have access to this type of training. While we fully support these initiatives and acknowledge the good work they are doing to bring this training back within reach of school pupils, we feel that learning about how to choose and prepare healthy meals should be an integral part of every young person's education, not an optional extra delivered only periodically. This is currently not the case. We recommend that the Government takes steps to reformulate the Food Technology curriculum, so that children of all ages receive practical training in how to choose and prepare healthy food which they can put into practice in their daily lives. As well as practical cookery lessons and classroom lessons about nutrition, children should also be taught how to understand food labelling and how to distinguish food advertising and marketing from objective fact; they could put their knowledge to the test in visits to a local supermarket. Healthy Schools initiatives have demonstrated the additional value of engaging children in projects to grow their own fruit and vegetables, fostering an understanding of where foods come from as well as reinforcing their motivation to eat more healthily. This should also form part of the food curriculum in schools. In order to achieve this, steps will need to be taken to strengthen teacher training in these areas.**

175. **We recommend that delivery of the Food Technology curriculum should be rigorously inspected by Ofsted.**

176. Although it is clearly vital to educate individuals and equip them to choose healthy options, whether in the classroom or through wider health promotion campaigns, making healthy decisions can be difficult even when people are well aware of what is good for them and what is not. The Food Commission argued very strongly that:

> The obesogenic environment needs to be tackled at the highest levels. It is not adequate to focus on the individual, especially the child, and expect them to exercise self-control against a stream of socially endorsed stimuli designed to encourage the consumption of excess food calories.[202]

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199 Q1509

200 Ibid

201 Department for Education and Skills, http://www.dfes.gov.uk

202 Ev 81

177. The central tenet of this argument was in fact backed up by the Department's own written submission to our inquiry, in which they acknowledged that while many of the determinants of obesity risk were controlled by personal choice, other, wider circumstances also played a significant part:

> People's exposure to risk reflects, in part, the choices they make about how to live their lives. But these are also heavily influenced by the circumstances in which they live—people do not have equal opportunities to make healthy choices.
>
> Industry has a responsibility to make it easier for consumers to choose a healthy diet, remove some of the barriers that can make it difficult to do so and provide clear and consistent information about their products.[203]

178. Recent comments from the Secretary of State for Health and the Minister for Public Health imply a belief that the public must share the responsibility for their own health, rather than rely entirely on government.[204] Given this, it is perhaps not unreasonable to speculate that the forthcoming White Paper on public health may adopt an approach that gives government the responsibility for educating people about the dangers of obesity and how they might be avoided, and leaves people to make their own decisions. However, there are serious doubts about whether such an approach would be sufficient to reverse trends in obesity, underpinned as they are by the current obesogenic environment. Evidence suggests that the vast majority of people are amply aware of the importance of healthy eating, but, as Tim Lobstein for the Food Commission told us, cultural and economic pressures outweigh the healthy eating messages they receive. According to Jackie Cox, Joint Chair of TOAST (The Obesity Awareness and Solutions Trust), there is a great misunderstanding of the problem of obesity:

> It has been seen as just a food problem—so if you teach somebody how to cook a low-fat chocolate cake, they will be cured; whereas most people in this country are quite knowledgeable about whether they should have an apple or a Mars bar, and that they should walk about more and so on.[205]

179. Professor Prentice also argued that the impact of health education was limited:

> I have gone through a transformation myself of thinking that we could do it all through education and have come to the conclusion that that is not working. I am not a nanny-statist but I am a health professional and I do think we have a responsibility to look after the health of the population.[206]

180. This diagram, shown to us by Professor Pekka Puska of the Finnish Health Institute, provides a helpful illustration of the individual's challenge to live a healthy life, in the face of a rising gradient of societal pressure to live unhealthily. While ultimately individuals must meet this challenge themselves, government can play a role both by providing

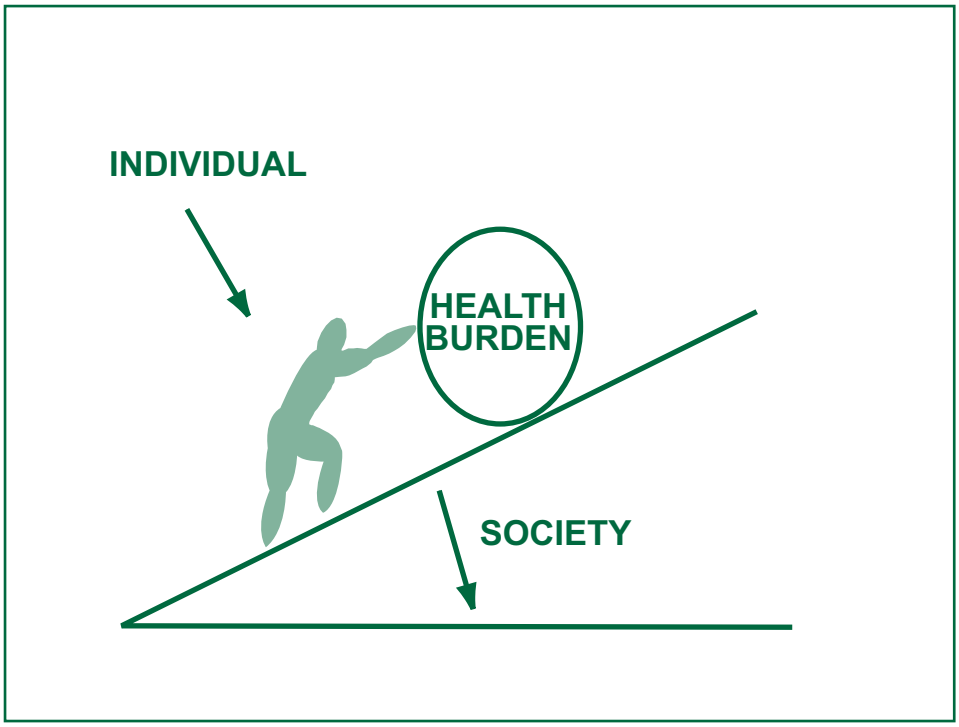
203 Ev 9

204 For example, "All talk and no action on obesity", *The Guardian*, 7 May 2004

205 Q1109

206 Q312

individuals with support as they climb, and by lowering the gradient against which they are climbing.



181. **Health promotion campaigns, as the recent anti-smoking advertising campaign has demonstrated, can play a successful role in raising awareness of the risks associated with particular behaviours, and to this end we have recommended that a health education campaign targeting obesity is launched as soon as possible. However, our evidence suggests that obesity has increased rapidly despite the fact that the benefits of a healthy diet have been well known for over 20 years. While we accept that individuals have the right and the responsibility to make choices about their own health and lifestyle, and we accept the importance of health education in enabling them to do so, we believe that to tackle obesity successfully education must be supported by a wider range of measures designed to remove the key barriers to choosing a healthy diet. We therefore recommend that the Government should concentrate its efforts not solely on informing choice, but also on addressing environmental factors in order to, in its own words, make healthy choices easier to make.**

Food advertising and promotion

182. While there is clearly a role for well designed and targeted health promotion schemes, one of the main doubts about their effectiveness centres on the huge financial weight of the food industry which is, by and large, directed at promoting entirely the opposite message, as articulated by Tim Lobstein of the Food Commission:

> Too much reliance has been placed on health education and handing out the odd leaflet in doctors' surgeries over the last 20 or 30 years as the Department of Health's strategy. It is not adequate. The main reason it is not adequate, of course, is that for every pound the Health Education Authority used to spend on promoting healthy diets there is about £800 being spent by the food industry encouraging us to eat their

> products. Of those products, about 95% are ones that would have encouraged weight gain rather than a healthy diet.[207]

183. Particular concern has been voiced about advertising food to children, which has been shown to have a demonstrable effect not only on brands but also on the categories of foods children eat. So how far is it desirable or possible to stem the seemingly continuous stream of messages children receive promoting unhealthy foods? The solution posited by Tessa Jowell MP, Secretary of State for Culture, Media and Sport, in her evidence was that, rather than imposing restrictions or controls on the promotion of unhealthy foods, these should be countered with the promotion of healthy foods. Equally surprisingly, she went on to suggest that it should be the advertising agencies and the food industry themselves who made this investment. While we are strongly in favour of the industry being part of the solution to this problem, the Secretary of State's view struck us as rather naïve.

184. Advertising agencies are commercial businesses and cannot be expected pro-actively to fund the large-scale promotion of healthy foods for the public good. They will clearly only be able to put their 'creative genius' to good ends if they are commissioned and paid to do so, which raises the question of who might reasonably be expected to provide such funding. Government health education campaigns are one answer, but we have already seen the insignificance of Government health education budgets compared to the advertising budgets of multinational food and drink companies. Even with sustained new investment it is difficult to see that the Government would be willing or even able to match this year on year. The other option would be to rely on the food industry itself, but given that currently the fruit industry spends on advertising just 2% of the amount spent on advertising unhealthy snacks, achieving equality between healthy and unhealthy foods does not seem a realistic aim.

185. **While we would clearly support an expansion in the promotion of healthy foods to redress the balance which currently lies entirely in favour of unhealthy foods, this alone seems to be an idealistic and ill thought-through notion, one which we are surprised that the Secretary of State for Culture, Media and Sport was prepared to espouse.**

186. In the absence of this as a realistic option, the other way to redress the balance would be to impose some degree of control on the promotion of food to children. While the industry position on this is clear, this option is already under active consideration by the Government, who identified the role of regulation, particularly in relation to advertising, as an important area for consideration in the Department of Health's public health consultation, published in March 2004. The Secretary of State for Culture Media and Sport has already expressed her "scepticism" about measures targeting the advertising of food to children:

> Why am I sceptical? Well, first of all, of course I recognise the very powerful alliance that has come out today in support of a ban. Of course we will await the advice of the Food Standards Agency later this month and I will receive advice in the summer from the media regulator, OFCOM [Office of Communications], about whether or not codes that regulate food advertising on children's television are sufficiently robust. This is an extremely complex issue … The reason that I am sceptical is that

207 Q302

> we have got to come back to the evidence. Why are we getting fatter? We are getting fatter because we are less active. [208]

187. However, the FSA has already accepted that evidence suggests that promotional activity influences children's eating habits. In the FSA's action plan, it argues that "action to address the imbalance in TV advertising of food to children is justified", and goes on to say that "action on advertising during children's TV slots would be likely to have some beneficial effect, and wider action might also be justified."[209]

188. There are recent precedents for advertising bans, both in the UK and abroad. The Co-op supermarket has already taken unilateral action in this area, by stopping all its advertising of 'unhealthy' foods and drinks during children's television programmes, as has Cadbury's.[210] Several countries have also introduced statutory regulation, or made government recommendations for strengthened voluntary controls:

- Sweden does not permit advertising aimed at children under 12, does not allow programmes to be interrupted by advertising and does not permit advertising before or after children's programmes.
- The Canadian province of Quebec prohibits all marketing aimed directly at children aged under 13.
- Norway is seeking a ban on advertisements before, during or after children's programmes.
- The Flemish region of Belgium does not permit advertising five minutes before and after programmes for children aged under 12.
- In the Netherlands the public broadcasters are not allowed to interrupt programmes aimed at under 12 year olds with advertisements.
- In Denmark, Finland and the Netherlands, characters or presenters from children's programmes cannot appear in advertisements.
- In Finland, McDonald's cannot promote toys in its advertisements.[211]

189. The Broadcasting Committee of Ireland is reported to have drafted a code whereby fast-food advertisers will be obliged to warn children that their products should only be eaten in moderation and as part of a balanced diet; advertisements for cakes, biscuits, sweets and chocolates will have to show a toothbrush symbol. Advertisements for food and drink will not be able to portray or refer to celebrities or sports stars.[212]

190. A counterargument we heard employed frequently by those who opposed restrictions on advertising food and drink to children was that no evidence yet existed that such

208 BBC Radio 4, The Today Programme, 3 March 2004

209 FSA Paper 04/03/02, 11 March 2004, pp 8-9, www.food.gov.uk

210 Co-op, *Blackmail*, p3

211 International Association of Consumer Food Organisations, *Broadcasting Bad Health*, July 2003, p24 and http://www.childrensprogramme.org/regulate.html

212 See www.irishhealth.com

restrictions directly yielded reductions in childhood obesity.[213] It is also the case that many children watch programmes aimed at adults such as Coronation Street, which is actually sponsored by Cadbury's (although advertising slots during such programmes are considerably more expensive). In addition, children may also be exposed to messages promoting unhealthy foods through many other media such as the internet and satellite television.

191. However, logic dictates that if advertising has an effect on the categories and quantities of foods that children eat, then removing that advertising would mean that this effect was gradually lessened, although the impact of this might not be felt immediately. Furthermore we strongly endorse the view taken by Derek Wanless that lack of evidence should not of itself be a reason for inaction.

192. **Given the scale of the public health hazard the country is confronted by, it would seem appropriate to employ a precautionary approach where evidence is contradictory. As we have said previously, we are committed to long-term solutions to the problem of obesity. The Hastings Review offered stark evidence of the extent to which advertisers of less healthy foods were saturating broadcasting slots targeting children, who are often watching without any adult present. While we would not want to go so far as to call for an outright ban of all advertising of unhealthy food, given the clear evidence we have uncovered of the cynical exploitation of pester power we would very much welcome it if the industry as a whole acted in advance of any possible statutory control, and voluntarily withdrew such advertising. There is clear evidence that the majority of parents do not favour such advertisements during children's television.**

193. **In one crucial sense, however, we share a concern about the effectiveness of banning or controlling television advertising: as noted above it is only a small part of the enormous food marketing effort that is aimed at children. If television advertising were to be banned, the marketing effort would simply be displaced to other areas—money previously spent on television advertising would, for example, be diverted to point of sale or internet promotion.**

194. **We gather that the Secretary of State for Culture, Media and Sport is in discussion with OFCOM over the marketing of less healthy foods. We would like her to review the whole marketing function. In particular, we would like her to address some of the issues the Irish Broadcasting authorities are looking at, namely the impact of product endorsement of less healthy food by sports stars, and other celebrities; guidance on how these products can actually fit into a healthy diet, perhaps linking into nutritional information; and their impact on the energy equation in terms of the activity needed to displace the calories they add. Assuming the food and advertising industry is genuine in its desire to be part of the solution, a starting point for this would be for companies to agree clear public health targets.**

195. **As we noted earlier, we were disturbed at the ineffectiveness of the Advertising Standards Authority, which is an industry self-regulation system. We recommend that OFCOM be asked to review the role of the ASA with a view to improving its**

213 See, for example, Q864.

effectiveness. This is not the first occasion on which the Health Committee has found the performance of the ASA to be disappointing.[214]

196. Children are subject to an onslaught of food promotion in many aspects of their daily lives, and the school environment appears to be no exception, with sponsorship by food companies and vending machines selling only unhealthy products now commonplace. When we put this to Margaret Hodge, the Minister for Children, she replied simply that this was a matter for individual schools and headteachers:

> I think it would be wrong for us in the DfES or for us in Government to prescribe from the centre what individual schools should do in relation to where they seek sponsorship. What we have done is to give guidance to say that they should measure the advantages and make sure that the educational advantages gained from a particular form of sponsorship outweigh the disadvantages and that has to be a decision for them … the individual headteacher ought to decide himself or herself what vending machines to have or what other form of promotion he or she chooses to have within their institution, and weigh up the economic and educational benefits against the disbenefits.[215]

197. However, there seems to us no logic at all in assuming that children in some areas might 'benefit' from exposure to such commercial pressures while others would be harmed. This is surely an area crying out for central guidance and direction.

198. Margaret Hodge went on to suggest that the impact of school was limited compared to the messages children received at home, arguing that "the greatest influence on children and the outcomes they achieve is the quality of parenting in the home" and that her priority would lie in "seeing how we can better support parents". However, we believe that the school is a crucial environment in which messages about nutrition—whether healthy or unhealthy—can be learnt and reinforced, sometimes resulting in children introducing to their parents healthier eating patterns learnt at school. Indeed, this is a central tenet of the Government's free school fruit campaign. We have also received evidence suggesting that children respond positively to the availability of healthy options. Where they have been trialled, vending machines selling only healthy foods have yielded a high turnover.[216]

199. **We feel that the school environment can have a strong influence over children's developing nutritional habits, and that the Government must not neglect this crucial opportunity to promote healthy eating to children and help them develop sound lifelong habits. Healthy eating messages learnt through the national curriculum and Government healthy eating initiatives such as the schools fruit campaign will be contradicted and undermined if, within that same school environment, children are exposed to sponsorship messages from unhealthy food manufacturers, and given access to vending machines selling unhealthy products. There is evidence that parents are keen to see unhealthy influences removed from schools, with recent research finding that as many as 70% of parents were in favour of banning vending machines in**

214 See eg Health Committee, Fourth Report of Session 2000–01, *The Provision of Information by the Government Relating to the Safety of Breast Implants*, HC 308, para 31.

215 Q1487; Q1493

216 Food Standards Agency, *A feasibility study into healthier drinks vending in schools*, Health Education Trust, March 2004, www.food.gov.uk.

schools.[217] **Recent research by the FSA also indicates that children are willing to purchase healthier drinks from vending machines when they are given the option. Given the worryingly steep rise in levels of childhood obesity, we feel that parents, teachers and school governors must all be fully engaged in tackling it, and that obesity should command a high priority on school board agendas.**

200. **We therefore recommend that all schools should be required to develop school nutrition policies, in conjunction with parents and children, with the particular aim of combating obesity, but also of improving nutrition more generally. In conjunction with this, the Government should issue guidance to all schools strongly recommending that that they do not accept sponsorship from manufacturers associated with unhealthy foods or install vending machines selling unhealthy foods. If Government insists that this is a matter for local determination, we believe that governors should permit such practices only if these are shown to be supported by a clear majority of parents. The guidance should also give firm support for the replacement of existing vending machines with ones selling healthy foods and drinks.**

Food labelling

201. Food labelling is a tool that could potentially enable consumers to choose healthier foods and negotiate their way through today's 'obesogenic society' more successfully. However, current labelling appears to fall far short of this aim. To begin with, the absence of legislation in this area means that nutritional labelling is often entirely absent from foods, and where it is present, is often complex, difficult to interpret, and in illegibly small print. Nutritional information panels are often overloaded with information, much of which may be irrelevant to the needs of today's consumers. For example, Dr Mike Rayner, Director of the British Heart Foundation, Health Promotion Research Group, argued that although when the 'Big 8'[218] standard nutrition label was devised protein deficiency was still a problem for some people in this country, almost no-one suffers from this problem any more, making the inclusion of protein on nutrition labels largely redundant.[219]

202. As well as the absence, inconsistency and irrelevance of information, the crux of the problem lies in the intelligibility of nutritional information on food labels. Sue Davies, for the Consumers' Association, told us that:

> Part of the problem is that even if you had the most comprehensive nutrition information, it is very difficult—and I have difficulty, as a consumer—to know how much fat I am supposed to have and what is a high amount of salt or a high amount of sugar. When people are shopping in a hurry, they do not want to be doing all of those calculations in their head, do they?[220]

203. Dr Mike Rayner told us that "everybody agrees that the nutritional labelling panel is completely incomprehensible, and people cannot make sense of the numbers, and there are

217 'Ban Junk Food from Schools, says poll', *The Guardian*, 22 October 2003

218 The 'Big 8' are defined as: energy, protein, carbohydrate with declaration of sugars, fat with declaration of saturates, dietary fibre, and sodium.

219 Q1166

220 Q1151

too many numbers."[221] According to the Consumers' Association, research suggested that consumers liked to see simple, bold claims such as 'low fat' on products, because it helped them make decisions when shopping in a hurry, without having to negotiate the nutrition panel.[222]

204. However, a problem frequently brought to our attention during the course of this inquiry was the impact of misleading nutrition claims, when products marketed as healthy failed to live up to that claim. We heard numerous examples, often relating to the fat content of foods, and in particular we were struck by the example of the cereal Frosties Turbos, advanced in evidence from the Consumers' Association. Using a series of eye-catching symbols on the front of the packet, Kellogg's claim that Frosties Turbos are good for bones, good for concentration, good for heart health and low in fat. What is not mentioned is that they are made up of 40% sugar, and that other, less sugary breakfast cereals might provide similar benefits with fewer calories.[223]

205. Andrew Coslett, for Cadbury Schweppes, argued compellingly that "an average supermarket can carry about 20,000 lines, and to try to get mum to understand every one of those in making a balanced diet is a challenge."[224] Besides improving the consistency and transparency of nutrition claims, our evidence suggested that consumers also need a simplified system of nutritional labelling for choosing foods to make up a balanced diet. The difficulty consumers may have in researching and understanding the calorie content in different foods is perhaps reflected by the fact that commercial weight management programmes often provide their customers with far simpler alternative systems for making nutritional decisions, such as the Weight Watchers Points system. However, devising a universal food classification system such as this goes to the heart of the argument surrounding whether or not any foods can reasonably be deemed 'good foods' or 'bad foods', 'healthy foods' or 'unhealthy foods'.

206. Food manufacturers have attempted to draw a clear distinction between food and tobacco, arguing that while there is no such thing as a safe cigarette, there is no such thing as a food which, seen in isolation, is dangerous:

> I think health warnings are for dangerous things. Whilst we recognise the problem I do not think that a Curly Wurly is a dangerous thing.[225]

207. This argument has been expanded and repeated by almost all those working in or concerned with the food industry presenting evidence to us, namely that there is no such thing as a healthy or unhealthy food, only healthy and unhealthy diets.[226] This was also the view expressed by the Secretary of State for Culture Media and Sport, and Sue Campbell, Chairman of UK Sport and Chief Executive of the Youth Sport Trust.[227] However, Dr Mike Rayner told us that in his opinion this myth was beginning to be broken down, ironically

221 Q1148

222 Q1143

223 Q1153

224 Q791

225 Q897 (Andrew Coslett)

226 Q726, Q738, Q920

227 Q535

by the very actions of government and industry. Citing schemes by government and industry to promote fruit and vegetable consumption, he argued that:

> If we are going to eat more of good foods like fruit and vegetables, then surely we have to eat less of some bad foods like confectionery, fizzy drinks and so forth? The labelling of good food … is quite often used by the industry anyway. They quite often have "healthy eating" ranges, so they are quite content to have this notion of good food. However, again, if we are going to be eating healthy foods, then there must be, conversely, just on a logical basis, some bad foods out there.[228]

208. The Public Health Minister also accepted this point:

> *Mr Burstow*: Do you accept that some foods can be classified as junk foods?
>
> *Miss Johnson:* I think we would all, in common parlance, accept that there are some foods that would be regarded as junk foods … I think we all know what sort of food stuffs are being referred to, broadly speaking. It is true, of course, that a small amount of any of these foods or these foods taken in on an irregular basis will not particularly harm you in themselves. It is the degree of frequency and the size of portions that is the issue.[229]

209. Sue Davis, for the Consumers' Association, supported this view:

> We have got to get over this issue about "there is no such thing as 'good' food and 'bad' food." There are definitely foods we need to be eating less of and foods we need to be eating more of, and it needs to be made clear on the front of the pack.[230]

210. Our witnesses were clear about the need for an integrated system, on the front of food packaging, to enable consumers to make an overall judgement about the food they were about to purchase. However, they did not feel that the extreme measures feared by the food industry, such as putting health warnings on high energy density foods, or labelling them with a skull and crossbones, were either reasonable or necessary. They felt strongly that food labelling and classification did not need to be pejorative, and Dr Mike Rayner instead suggested the possibility of introducing a symbol to demarcate "fun foods" or "treat foods", highlighting the need to eat them sparingly rather than regularly.[231] As Sue Davies argued, the point of such a system would be "to highlight the good, bad or in-between foods. It is not saying 'do not eat this food', it is saying 'do not consume it very often; do not eat it all the time.'"[232]

211. We also heard the suggestion that in order to link calorie consumption to energy output, food labelling could include a requirement to state how much exercise would be

228 Q1170

229 Q1386

230 Q1168

231 Q1179

232 Q1168

required to burn off the calories in a particular product—for example, a Mars bar would require four miles of walking for an adult.[233]

212. In Sweden, a simple system is already in place to enable consumers to identify foods that are lower in fat and higher in fibre. Under the Swedish 'Keyhole' system, a green keyhole symbol appears on the front of foods that are lower in fat or high in fibre, although it is not included on produce which is naturally lean or high in fibre, such as lean meat and fruit and vegetables. The symbol appears on, amongst other things, low-fat sausages, cheese, ready-meals and fibre-rich breads. Products must meet strict criteria about the proportion of fat, sugar and dietary fibre they contain before they are able to use the symbol.[234]

213. The FSA told us that they believed that the law relating to food labelling needed to be reviewed and changed.[235] These changes, in their view, should include making the provision of nutritional labelling compulsory.[236] They also supported a 'high/medium/low' format of labelling as the approach that worked the best with consumers, and agreed with the concept of nutritional signposting on the front of food packaging.[237]

214. **Nutritional labelling is intended to help consumers make sound nutritional decisions when buying food, but the current state of such labelling seems to be having, if anything, the opposite effect. We have repeatedly heard the argument, both from the food industry and from the Government, that there are no such things as good or bad foods, only good or bad diets. However, both the food industry and the Government have embraced the concept of labelling certain foods as 'healthy' with great enthusiasm, inviting the obvious conclusion that other foods must be, by definition, less healthy.**

215. Dr Mike Rayner told us that the Co-op had improved the nutritional panelling on foods and now used the categories "high" "medium" and "low" on the panel, a measure which we strongly commend.[238] Indeed, the Co-op's labelling as a whole struck us as exemplary in comparison with what most supermarkets managed. Dr Rayner also suggested that a voluntary scheme to improve labelling was only likely to be effective if all the major supermarkets agreed on a common scheme.[239]

216. **The Government must accept the clear fact that some foods, which are extremely energy-dense, should only be eaten in moderation by most people, and we therefore recommend that it introduces legislation to effect a 'traffic light' system for labelling foods, either 'red—high', 'amber—medium' or 'green—low' according to criteria devised by the Food Standards Agency, which should be based on energy density. This would apply to all foods. Not only will such a system make it far easier for consumers to make easy choices, but it will also act as an incentive for the food industry to re-**

233 Q1179

234 Swedish National Food Administration, http://www.slv.se/engdefault.asp

235 Q1258

236 Q1259

237 Q1273

238 Q1148

239 Q1160

examine the content of their foods, to see if, for example, they could reduce fat or sugar to move their product from the 'high' category into the 'medium' category.

217. **Bearing in mind Derek Wanless's suggestion that greater effort needs to be made to measure the effectiveness of different interventions, we believe that this recommendation would lend itself well to objective assessment. If the scheme we propose is accepted, it would be relatively simple to measure the impact on the range of relatively healthy and unhealthy foods offered by supermarkets, and any shift in the patterns of consumption from relatively unhealthy to relatively healthy products.**

Food composition

218. It is indisputable that high energy density foods have a particularly pronounced impact on weight gain. The Department stated in its memorandum that the *NHS Plan* included commitments to initiatives with the food industry to improve the overall balance of diet including salt, fat and sugar in food, working with the FSA. However, the Department's memorandum does not suggest that this has been pursued as a high priority or that significant progress has been made:

> Discussions with the food industry and retailers are underway on reducing the level of salt in processed foods. These discussions have demonstrated that industry have made some steps towards reducing salt in processed foods but there is scope for further action. The situation is likely to be similar for fat and added sugars. Options for working with industry on these areas will be considered through 2003–04.[240]

219. Describing the progress made so far in this area in oral evidence, Imogen Sharpe, for the Department, told us that liaising with industry to reduce salt levels, which contribute to high blood pressure although not to obesity, had been tackled as a priority over and above fat and sugar levels under specific instructions from the Chief Medical Officer.

220. The Rt Hon Alan Milburn MP, the previous Secretary of State for Health, has recently issued forthright demands for the Government to tackle food composition as a priority:

> Specifically an ultimatum needs to be placed before the industry that unless it voluntarily cuts fat, sugar and salt in food within a specified time frame then tough regulatory action will be taken to ensure that it does.[241]

221. While lowering the fat content of foods would seem a sensible aim, Professor Andrew Prentice pointed out to us that this would not achieve the objective of reducing obesity if, as he believed was already happening, food manufacturers substituted fat with other highly energy-dense foods, such as refined carbohydrates and sugars, in order to keep selling the products to people who had acquired a taste for energy-dense foods.[242] Professor Prentice argued compellingly that it was energy density that needed to be targeted rather than just fat.

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240 Ev 18

241 "From sick care to health care: meeting the challenge of chronic disease", speech to Oxford Vision 2020 Conference, 3 December 2003

242 Q291

222. **We note the Government has made efforts to date to reduce salt levels in foods, but we feel that urgent attention should also be given towards tackling obesity. We recommend that, rather than targeting sugar and fat separately, the Government should focus on reducing the overall energy density of foods, and should work with the Food Standards Agency to develop stringent targets for reformulation of foods to reduce energy density within a short time frame. While we expect that reformulation could be achieved through voluntary arrangements with industry, and while we believe that the introduction of legislation in respect of labelling will encourage industry to make the entire product range healthier, the Government must be prepared, in the last resort, to underpin this with tougher measures in the near future if voluntary measures fail.**

Food pricing

223. Research has shown price to be a key factor in people's food choices, and our evidence suggests that particularly for lower income families economic concerns may override any health information.[243] Changing food prices to influence people's decision-making in favour of healthier foods could be achieved in two ways—either by increasing the prices of unhealthy foods to act as a disincentive for consumers to purchase them, or by introducing measures to lower the prices of healthy foods, making them affordable to all. In evidence to us, the Department was reluctant to discuss these issues, arguing that "obviously, it is not for government to tell industry how much they charge for a particular food." However, they did state that the forthcoming Food and Health Action plan would be considering food production, supply and availability, and within that equality of access to food.[244]

224. Opinions vary widely on the issue of introducing fiscal measures to raise the prices of high energy density or fatty foods. According to media reports, a paper prepared by the Downing Street Strategy Unit argued that the extension of VAT for some dairy produce, fast food and sweet foods would act as "a signal to producers as well as consumers and serve more broadly as a signal to society that nutritional content in food is important."[245] A report in the *British Medical Journal* also claimed that a fat tax could prevent 1,000 premature deaths from heart disease alone every year in the UK.[246]

225. However, critics of the idea contend that, as with any 'vice tax', rather than changing their behaviour people simply divert spending from other necessities. It has been suggested that a fat tax would disproportionately affect lower income families, who already spend a higher proportion of their income on food and drink. The plans have also attracted criticism for ideological reasons: according to Martin Paterson, of the Food and Drink Federation, "Consumers will rightly feel patronised by 'top-down' messages based on the idea that they can't think for themselves and need to be taxed into weight-loss."[247]

243 Q303; *FSA Survey*, 2001

244 Q127

245 "Government unit urges fat tax", BBC online news, 19 February 2004

246 T Marshall "Exploring a fiscal food policy: the case of diet and ischaemic heart disease", *British Medical Journal* 320 (2000), pp 301-304

247 http://news.bbc.co.uk/1/hi/health/3502053.stm

226. Value Added Tax is already levied on certain 'treat foods': savoury snacks, ice cream, confectionery and fizzy drinks (including zero calories diet drinks) all incur VAT at 17.5%. PepsiCo pointed out in their written memorandum that this has given rise to an anomalous situation, in that other, similar treat foods are zero rated, such as cakes, cake bars, plain biscuits, Jaffa cakes, cookies, Bourbon biscuits and Ginger Bread Men with chocolate eyes—but the addition of chocolate buttons on to any of these products would result in VAT being levied.[248]

227. The healthcare costs of obesity rehearsed earlier illustrate how the NHS and society have to pay for causes out of their control. The price of cheap, fatty, sugary foods, for instance, does not include the healthcare costs that may follow much later from excess consumption. In formal economic terms, when consumers purchase cheap calories, there may be further indirect costs much later. This raises complex issues which the Wanless Reports have begun to address. The recent World Health Organisation draft strategy on diet and physical activity suggested that member states consider taxes and other fiscal measures to send more health-enhancing price signals to consumers.[249]

228. **The notion of taxing unhealthy foods is fraught with ideological and economic complexities, and at this stage we have not seen evidence that taking such a significant and difficult step would necessarily have the hoped-for effect of reducing obesity. We recommend, instead, that the Government should keep an open mind on this issue, and monitor closely the effect of fat taxes introduced in other countries. We also recommend that the Government should take steps to address the anomalies in the current arrangements for VAT on unhealthy 'treat' foods as it is clearly ludicrous that VAT is levied on ice cream and fizzy drinks but not on Bourbon biscuits or cakes.**

229. The other side of the food pricing equation would be to attempt to lower the prices of healthy foods so that they present a realistic and affordable alternative for everyone, as currently healthy foods, both 'healthy' versions of pre-prepared foods, and naturally healthy fruit and vegetables, can cost significantly more than non-healthy alternatives.

230. **We hope that as the Government and food industry work together to reduce the energy density of foods, the need for 'healthy' options will be gradually reduced, with standard versions of foods being healthy as a matter of course. However, as this is likely to be a phased process, we recommend that in the short term the Government must work with the food industry to ensure that 'healthy' versions of foods, with reduced calories and fat, are available at an affordable price.**

231. Evidence suggests that there may be considerable scope for trimming the profits attached to fresh fruit and vegetables, as according to Friends of the Earth, fruit and vegetables are significantly cheaper in street markets than in supermarkets.[250] DEFRA put average 'farm gate' prices (what a grower actually takes, after paying the costs necessary to supply the supermarket, including grading, packaging and transport) for Cox apples in

248 Ev 230

249 WHO, Global Strategy on diet, physical activity and health A57/9, 17 April 2004

250 www.foe.co.uk

October 2002 at £0.33 per kilo, while the average supermarket retail price for the same period was £1.45 per kilo.[251]

232. This inquiry has not probed in depth the complexities of European agricultural policies. However, it is clear that while the potential for the CAP to work in concert with public health policy has been recognised for over 20 years, numerous attempts to reform the CAP to these ends have failed. The UK's Committee on the Medical Aspects of Food Policy recommended that the Government should review the CAP's impact on diet as long ago as 1984, arguing that "consideration should be given to ways and means of removing from the Common Agricultural Policy those elements of it which may discourage individuals and families from implementing the recommendations for dietary change."[252] More recently, in 1999 and in 2002, this has been raised by the World Health Organisation:

> Despite a call for public health to be considered in all EU policies in 1999, no review of the CAP objectives has occurred and public health is still not mentioned as a policy determinant in the Agenda 2000 reform or in the recent mid-term review of CAP.[253]

233. According to the Consumers' Association report on the CAP, "nutrition considerations have been given scant concern by agricultural policy makers, even though diet and health are closely linked."[254] The initial reluctance of DEFRA to contribute to our inquiry on obesity could be regarded as further evidence of this continuing lack of linkage between agricultural and health policy, and the fact that the Department of Health was the last government department to respond to the Curry Commission consultation on the future of food and farming could also be seen to indicate a lack of pro-active communication in this area.

234. When a representative of DEFRA, Mr Callton Young, did eventually give evidence to us, he stated that he had not come briefed to talk about the Common Agricultural Policy. However, he confirmed that:

> The CAP does have a role to play … in terms of the health and nutrition agenda. The price of food is very clearly linked to what people buy and the extent to which it is subsidised must have a feedback down the chain to the consumer.[255]

235. Mr Young agreed that the promotion of healthier food "has to be a part of the Common Agricultural Policy."[256] However, although he emphasised the need for government departments to "look at these things holistically", when asked why his Department had not mentioned nutrition on its website he argued that that was because "the lead policy responsibilities for nutrition and health reside with the Department of Health."[257] Mr Young said that the issue of the CAP had been raised at cross-governmental

251 Ibid

252 "Setting aside the CAP – the future for food production", Consumers' Association, 2001, p 13

253 WHO global strategy on diet, physical activity and health: European regional consultation meeting report, p. 11, Copenhagen, Denmark, 2-4 April 2003.

254 "Setting aside the CAP", p 48

255 Q1195

256 Q1196

257 Q1201

steering group meetings for the Food and Health Action Plan, but he feared that what could actually be done about the CAP was "a much more difficult nut to crack".[258]

236. Following on from our oral evidence session, DEFRA submitted written information on the CAP, in which they told us their policy objective was to "move away from a position where the market and demand have been distorted by over-supply of some products and measures to address that over-supply." This meant, in their view, that "to this extent we will be neutralising the CAP as a force which may have contributed to increasing obesity." However, DEFRA ended on a note of pessimism, stressing the need to be realistic about what reform of the CAP could and could not achieve, and arguing that "in reality the CAP is not a particularly important factor in causing obesity."[259] This attempt by DEFRA to distance agricultural policy from health by playing down its impact does not strike us as particularly helpful in achieving joined-up solutions to this problem across government.

237. **As a matter of urgency, the Government must redouble its efforts to reform the Common Agricultural Policy as part of the public health agenda, and the future UK presidency from July 2005 will afford an opportunity for this to be done. Obesity is, after all, a growing problem in almost all EU countries. The issue of agricultural policy presents a perfect opportunity for the Government to demonstrate that it is committed to tackling public health issues in a joined-up way, an opportunity which in our view it has to date entirely neglected. However, as noted above, progress on the CAP will be extremely difficult unless public heath is given much greater emphasis in Europe. We therefore call on the Government to use its influence, and its forthcoming presidency, to encourage the Commission to reconsider the Treaty of Rome and put public health on an equal footing with trade and economics.**

238. **In the interim, the Government, led by the Treasury should emulate the Swedish Government[260] and produce a Health Audit of the CAP, and build a stronger alliance of Health Ministries to combat other interests protecting the status quo in public policy.**

239. As well as healthy food being generally more expensive than less healthy alternatives, this inequity is compounded by the now widespread use of price promotions which are heavily biased in favour of unhealthy foods. This is now an accepted part of food marketing, ranging from 'buy one get one free' price promotions in supermarkets, to super-sizing of meals in fast food restaurants and 'meal deals' on take away lunchtime foods.

240. We note that there have been improvements overall in the numbers of supermarkets where there is no confectionery available at the till. We were interested to hear that ASDA, who came out worst in a Food Commission report into this area, were now trialling the sale of fruit and non-food items at the till. We look forward with interest to hearing how this trial has gone.[261]

258 Q1206

259 Appendix 59

260 L S Elinde et al (2003), *Public health aspects of the EU Common Agricultural Policy*, Stockholm: National Institute of Public Health

261 Q977

241. **During this inquiry we have heard repeatedly that industry is keen to be 'part of the solution'. If this desire is to be translated into reality, then supermarkets should adopt new pro-active pricing strategies that positively support healthy eating, rather than acquiesce in the view that their duty to their customers goes no further than simply providing the range of foods which they want to buy. As part of their healthy pricing strategies, supermarkets must commit themselves to phasing out price promotions that favour unhealthy foods, and also stop all forms of product placement which give undue emphasis to unhealthy foods, in particular the placement of confectionery and snacks at supermarket checkouts. Alongside this, all sectors of the food industry should collaborate in the phasing out of super-sized food portions. We expect that the food industry will be keen to capitalise on the significant commercial opportunity that introducing these policies will present, and indeed much good work has already been done in this area. Several supermarkets have already committed themselves to banning the placement of confectionery at checkouts, and Kraft and McDonalds have begun to limit the availability of super-size portions. We commend fast-food outlets for offering fruit and salad options, though we request that these should be promoted more effectively than at present. Those companies who do not comply with Government guidance on healthy pricing, including product placement and super-sizing, should be publicly named and shamed.**

Food in schools

242. Throughout our inquiry, the diet of children and young people has been a recurring theme. A survey conducted by the Consumers' Association in March 2003 asked 246 children to compile a food diary which revealed that, despite the fact that children seemed to know what foods were healthy and to understand the health implications of poor diet, children in Year 6 and the girls in Year 10 ate just two portions of fruit and vegetables per day with boys in Year 10 eating just 1.5 portions. Most children ate at least one bag of crisps a day, and many had sweets or chocolate every day.[262]

243. We have already discussed in detail the promotion of unhealthy foods to children in schools, through a wide variety of schemes embraced for the commercial benefit they bring to schools without consideration of their wider health implications. In our view these should be stopped immediately. We have also made recommendations to improve the teaching of cookery in schools to teach children to choose and prepare healthy meals. However, to support improvements in both of these areas, a good example needs to be set in the school meals provided by schools themselves, something that does not seem, at present, to be happening. Again, we cannot accept that this is a matter purely for local determination by schools. Children's nutritional requirements do not vary according to where they happen to go to school.

244. In the course of our inquiry we examined the standards for school lunches that have been adopted in England and Scotland. Technically, both Scotland's standards and England's guidance include the nutrient recommendations for school meals developed by Caroline Walker Trust Nutritional Guidelines for School Meals.[263] However, the placement

262 Ev 391

263 *Scottish Nutrient Standards*, Section 1.2 and Section 1, tables 1 and 2; England Primary School Guidance, Annex Cii; England Secondary School Guidance, Annex Cii

of the nutrient guidelines within Scotland's standards and England's guidance is telling. The nutrient requirements are located in the first section of Scotland's standards which emphasise that their achievement is "essential."[264] Moreover the overall tone is that compliance is required, or at least expected; the standards speak in terms of "should," "required," and "achievement," as well as stating maximums and minimums. To this end, the Scottish Executive has commissioned the development of nutritional analysis software to assist schools in self-evaluating the compliance with these standards.[265] Caterers will be able to utilise the software to analyse the nutritional content of recipes.

245. In contrast, we were disappointed to learn that England's guidance specifically and conspicuously states that only the regulations, which do not require any specific nutrient content, are compulsory and that the guidance on good practice is "not required by law."[266] The nutrient recommendations are placed in the back of the guidelines as an annex, where it is suggested, but not required, that an approximate nutritional analysis could be accomplished by the caterer, the school food committee using a computer software package, or by an independent expert such as a community dietician.[267] The overall effect of placing the nutrient recommendations at the end, pointing out that the guidance is not compulsory, and using terms such as "aim" and "try," is that the specific nutrient content of school meals is marginal.

246. We also learned that in Scotland, standards bar the provision of fizzy drinks as a part of a school meal in primary schools, and bar the encouragement of the provision of such drinks in secondary schools.[268] Crisps, as a part of a combination meal option/meal deal or packed lunch may only be offered twice per week.[269] Neither England's regulations nor guidelines bar, limit, or discourage the provision of crisps or fizzy drinks.

247. We were please to learn from the Minister for Children that the DfES has asked the FSA and Ofsted to conduct a review of the implementation of the nutritional standards for school lunches introduced in July 2000.[270] However, we were disappointed to learn that the scope of the review did not extend to include school breakfasts.[271]

248. **We recommend that the Department for Education and Skills extend the scope of the FSA review of the implementation of nutritional standards, with a view to developing appropriate nutrient based standards for school breakfasts.**

249. **Furthermore, we recommend that the Department for Education and Skills takes steps to ensure that all children eat a healthy school meal at lunchtime, both through improving the provision of attractive and palatable 'healthy' options, and through restricting the availability of unhealthy foods. The Government should shift from the current 'food-based' standards towards the 'nutrition-based' standards being**

264 *Scottish Nutrient Standards*, Section 1.5

265 *Scottish Nutrient Standards*, Section 1.4

266 England Guidance, Section 4

267 England Primary and Secondary Guidance, Annex Cii

268 *Scottish Nutrient Standards*, Section 2, "Menu Planning" table, Group 5

269 *Scottish Nutrient Standards*, Section 2, "Menu Planning" table, Group 5

270 Q1497

271 Q1501

introduced in Scotland. The quality of school meals should also be taken into account by Ofsted inspections.

Causes of obesity relating to physical inactivity: solutions

250. Making society as a whole more active is an extremely difficult task. As we have seen, the forces promoting sedentary behaviour have grown substantially over the last few decades. There are few grounds for optimism that there will be a reversal in these trends. More and more labour-saving devices are being created, car ownership continues to grow, traffic volumes continue to increase, local shops are being replaced with out-of-town stores, and fear of crime keeps people increasingly indoors. It will require a remarkable cultural shift if society is to become more active across all social classes; a trickle of pilot projects and local schemes will not be adequate.

251. The costs to the NHS of low levels of physical activity are high. Yet as Barry Gardiner MP pointed out to us, spending on treatment dwarfs spending on promotion of physical activity, which, if adequately tackled, could offset some of those considerable health costs:

> We spend £886 per head of population per year in providing what amounts to a national sickness service and we spend £1 per person per year on sports and physical activity which could actually prevent a lot of that sickness.[272]

252. As we have noted, the current Government target for physical activity for adults is 30 minutes of moderate activity 5 times per week. Yet currently only 32% of adults achieve this, less than a third of the population, compared to 70% in Finland. The lead department on physical activity is the Department for Culture, Media and Sport. In its document *Game Plan*, jointly produced with the Prime Minister's Strategy Unit in December 2002, DCMS set a very ambitious target that 70% of people in England should attain the current activity goal by 2020. As Sport England commented, "This presents the Government—and key partners—with an exacting challenge. To put it bluntly, 100,000 inactive people will have to be converted to physical activity every single month for the next 17 years if the Government's targets are to be met."[273]

253. In this section of our report we want to examine what is being done to boost activity levels. In doing this it is important to distinguish between two separate ways in which activity is achieved:

- *organised and recreational activity, in the form of sports and other activities either in schools or in the community; and*
- *activity within daily life, which embraces areas such as active travel and activity within the workplace.*

254. These areas are not, however, entirely discrete. For example, children walking or cycling to school are likely to be fitter than those who journey by car; they are more likely to enjoy and benefit from sport; and the sporting habits they develop at school are then more likely to feed into an active lifestyle when they attain adulthood.

272 Q1028

273 Appendix 19

Organised and recreational activity

255. It is by no means clear that countries with high levels of active recreation and sport will necessarily be less obese—Australia has some of the fastest growing levels of childhood obesity. It may be that boosting the facilities for active recreation will in fact exaggerate health inequalities since the middle classes are much better at accessing these. The Chief Medical Officer's recent report on activity and health emphasises that physical inactivity is not merely a critical factor in obesity but also is implicated in 20 other diseases and conditions and in particular hugely increases the risk of cardio-vascular disease, diabetes and cancer.[274] In the treatment of obesity, disease reduction is just as important as weight loss and the Chief Medical Officer also supported the notion that activity significantly reduces disease in the obese.

256. The impact of school-based activities is also complex. While there is no doubt that active children tend to be less overweight and indeed to achieve more academically, organised school sport seems to alienate many children, and there is ample evidence to suggest that much bullying begins in the changing room. But while school sport occupies only a tiny fraction of the child's waking hours—around 1% a year—it perhaps is most useful in fostering habits of activity which can last a life time.

257. *Game Plan* records that levels of participation in sport have not increased much in England in recent years. Only 46% of the population take part in sport more than 12 times a year compared to 80% in Finland.[275] Following a recommendation contained in *Game Plan*, Sport England, the body charged with the strategic lead for sport, working with relevant stakeholders, is developing a national database which will provide a comprehensive audit of community sports facilities. This database will provide guidance to Government Departments, Lottery Distributors and local authorities on needs-based strategic investment priorities. The database will also provide information for the public on what facilities exist and where they are located.

258. Sport England has been modernised following *Game Plan's* publication so that its objectives now explicitly acknowledge the significance of the health agenda and its responsibility to help promote active and healthy lifestyles.

259. Many different initiatives support sport in the community but in the longer term the uptake of sport will, we believe, be driven more by what is achieved with younger people than with adults. Most of our evidence on sport and PE has focused on young people. As Sue Campbell, for the Youth Sport Trust, remarked:

> There is no question now that young people are far more sedentary by nature almost and we are creating young people who are very computer-literate, who are very engaged with other forms of learning and have almost forgotten how to learn physically.[276]

274 *At least five a week*, p 9

275 However, a European Commission Survey conducted in December 2002, which relied on self-reported evidence, placed the UK roughly in the middle of EU countries for physical activity. See europa.eu.int.

276 Q492

260. In 1999, the then Secretary of State for Education, the Rt Hon David Blunkett MP, announced his intention to address declining physical activity in schools. The National Healthy Schools Standard encouraged schools to provide pupils with a minimum of two hours of physical activity within and outside the national curriculum. However, there is no method of compelling schools to meet this standard and obese children often continue to opt out of activities outside the main curriculum. The Child Growth Foundation was moved to describe "the continued absence of any National Curriculum amendment to provide every child with the two hours per week of enjoyable structured physical activity to which they are entitled" as a prime illustration of Whitehall's inability to tackle obesity. [277]

261. In October 2002, the Prime Minister announced an investment of £459 million to deliver "a national strategy for PE, school sport and club links."[278] Both the Department for Culture, Media and Sport and the Department for Education and Skills now have a PSA target that 75% of school children should undertake two hours of high quality PE and school sport each week by 2006, and a number of programmes have been put in place to support this. The Qualification and Curriculum Authority is also exploring ways of improving PE and sport in schools.

262. To help achieve the two hours weekly target, the Government is developing School Sport Partnerships.[279] These are families of schools that come together to enhance sports opportunities for all. The partnerships comprise: a specialist sports college, eight secondary schools and 45 primary or special schools clustered around the secondaries and the College. Each partnership receives a grant of up to £270,000 each year. This funds: a full time Partnership Development Manager, the release of one teacher from each secondary school for two days a week to allow them to take on the role of School Sport Coordinator, the release of one teacher from each primary or special school for 12 days a year to allow them to become Link Teachers; and Specialist Link Teachers who fill the gaps created by teacher release.

263. Six strategic objectives have been set for partnerships:

- Strategic planning—to develop and implement a PE/sport strategy.
- Primary liaison—to develop links, particularly between Key Stages 2 and 3.
- Out of school hours—to provide enhanced opportunities for all pupils.
- School to community—to increase participation in community sport.
- Coaching and leadership—to provide opportunities in leadership, coaching and officiating for senior pupils, teachers and other adults.
- Raising standards—to raise standards of pupils' achievement.

264. By 2006, there will be 400 partnerships including 75% of schools in England. A recent survey conducted for DCMS indicated considerable success for the scheme:

277 Appendix 24

278 Appendix 44 (DfES)

279 See DfES website at www.dfes.gov.uk.

> 68% of pupils in schools that have been in a partnership for three years, are spending at least two hours each week on high quality PE and school sport in and after school, rising to 90% at Key Stage 3. This compares to 52% for schools new to the programme.[280]

265. The Government has checked the trend established in the 1980s of local authorities selling off school playing fields to raise capital. Active protection (through legislation introduced in 1998) and strict planning regulations has resulted in an average of only three applications a month being approved, and almost half of these are at schools which are closed or closing. In all cases, any proceeds are being ploughed back into improving sports or educational facilities—the proceeds are not being spent on school books or teachers' salaries.

266. Some £581 million is being invested in England by the New Opportunities Fund with the aim of improving and increasing sports facilities at schools. This funding will be used to support projects designed to bring about a step-change in the provision of sporting facilities for young people and for the wider community, through the modernisation and development of existing and new facilities for school and community use (including outdoor adventure facilities), and the provision of initial revenue funding in support of these developments.

267. An investment of £130 million is being allocated to 65 Local Education Authorities through the Space for Sport and the Arts programme to develop new sports and arts facilities on primary school sites. As well as benefiting schools themselves, these premises will also be available for community use, with the emphasis on inclusion of currently under-represented groups.

268. **We commend the wide range of measures and substantial funding being directed by the Government towards physical activity, particularly in schools. While we have reservations about the effectiveness of measures taken to date, we wish to pay tribute to the efforts that have been made in the last two years and to acknowledge the substantial funding that has been provided.**

269. As we noted above, the majority of children still fail to achieve two hours per week of structured activity. In many cases, schools do not have the resources to provide the suggested amounts. A House of Commons Committee of Public Accounts report found that "achievement of children's entitlement of two hours of physical exercise a week requires an adequate and equitable distribution of facilities. There is, however, a considerable disparity in the opportunities for sport currently being offered to children by different schools."[281]

270. A large amount of anecdotal evidence—including accounts given to the Committee at the 'Watch It' clinic in Leeds—suggests that obese children are often bullied, a problem that may become more acute when children are involved in traditionally competitive school sports. Many children opt out of school sports as they find competitive team sports unattractive. The National Curriculum for Key Stage 2 states that PE should be taught

280 See DCMS website at dcms.gov.uk.

281 Committee of Public Accounts, Ninth Report of Session 2001-02, *Tackling Obesity in England,* HC 421, p 7

through dance activities, games activities, gymnastic activities and two activity areas from swimming, athletics and outdoor and adventurous activities, although there are no specifications within these areas, and no guidelines about how vigorous these activities should be. Guidance from the DfES also stresses that provision should encourage children to enjoy PE and be keen to get involved. It is clear then that schools need to offer a range of activities in order to attract all pupils. This, however, can be difficult when resources are stretched and facilities are inadequate.

271. Barry Gardiner MP, who gave evidence to us, has proposed a more radical plan which will be piloted in four schools in Brent North from September 2004, starting with pupils in Year 7. Here, the school day will be extended to run from 8:30am–6pm, which will allow the possibility of two guaranteed hours of sport in each school day. Mr Gardiner argued that as well as improving the health of school children, the scheme would provide a number of other indirect benefits such as a reduction in youth crime, improved scholastic achievement and increased social cohesion.

272. If playing sport is not possible for some children, Mr Gardiner proposes that music, art or drama could be taught instead, which would also help relieve pressure on teaching staff. To avoid children being put off sport for life they should instead be offered "a smorgasbord, a whole range of physical activities." This might range from "ethnic dance right through to boxercise."[282] Teachers for the PE session could be assisted by volunteers and School Sports Co-ordinators (a scheme organised by Sport England).

273. Mr Gardiner's scheme also recognises the need for healthy food in schools. His proposal provides children with healthy balanced meals—an optional breakfast club in the mornings, a nutritionally balanced lunch at 1pm followed by the two hours of sport from 2pm–4pm. There would follow another break which would incorporate a carbohydrate-based snack to keep the pupils going for the rest of the day. [283]

274. A project co-ordinator will supervise the Brent scheme and £150,000 is being devoted to evaluate it. According to Mr Gardiner, initial reaction from both teachers and parents has been enthusiastic.[284] However, the response from the Government so far had, in Mr Gardiner's words, been limited to "a great many kind words".[285]

275. **We regard it as lamentable that the majority of the nation's youth are still not receiving two hours of sport and physical activity per week. While we very much welcome the DCMS/DfES target to have 75% of school children thus active by 2006 we do not believe that this goes far enough. We have reservations about the quality of much of the activity undertaken, since little work has been done to establish what the two hours involves, and whether it includes, for example, time taken in travelling to and from facilities. Moreover, even the two hour target puts England below the EU average in terms of physical activity in school, despite the fact that childhood obesity is accelerating more quickly here than elsewhere.**

282 Q1022

283 Ev 300

284 Q1025

285 Q1033

276. **We recommend that, given the threat of obesity to the current generation of children and taking account of the proven contribution of physical activity to academic achievement, the aspiration should be for school children to participate in three hours per week of physical activity, as recommended by the European Heart Network.**

277. **Relentless pressure on the curriculum has served to squeeze out school sport and PE. However, there is ample evidence that being physically active benefits children's academic performance, and many schools in the independent sector offer four or more hours of exercise per week. We know that the Government is monitoring closely the Brent project but that it has been less than forthcoming with supportive funding. We believe that this is a fascinating pilot project and would like to see it rigorously evaluated. Given its potential importance as a model, we also think it would be helpful if the Department's favourable initial appraisal of the scheme were supported by funding.**

278. **We recommend that the Curriculum Authority should address ways of diversifying organised and recreational activity in schools to embrace areas such as dance or aerobics to broaden the appeal of PE and to counteract the elitism, embarrassment and bullying that the changing room sometimes creates.**

279. **We do not think it appropriate that the activity of a school in delivering the physical activity agenda should be extrinsic to any evaluation of its overall performance. Physical activity is not—or should not be—a second order consideration. Not only is it crucial to children's health but it also directly benefits academic performance. So we recommend that the Ofsted inspection criteria should be extended to include a school's performance in encouraging and sustaining physical activity.**

280. The psychosocial aspects of obesity, which are often ignored in the drive to improve physical health, are particularly important in children. Obese children are frequently bullied and school sport can prove a humiliating experience. **We recommend that the Department for Education and Skills, as part of its wider work to improve self-esteem and self-confidence amongst school children, should ensure that each school, as part of its policy against bullying, remains alert to the particular issue of bullying of children who are overweight or obese. Teachers should receive training in children's diet, physical activity levels, and how to help obese children combat bullying, without further stigmatising them.**

Active lifestyles

281. When physical activity is mentioned, what springs to mind most readily is probably what Susan Jebb termed "programmed, planned exercise", such as joining a local sports team, going to an aerobics class, or using an exercise bike. However, as Living Streets argued, "for many people, joining a gym or taking part in a team sport are not realistic options—for economic or time reasons."[286] Our witnesses stressed repeatedly that rather than promoting planned sport or active recreation, which might require life changes that were unsustainable, a far more useful and realistic aim was to increase activity levels within

286 Ev 163

people's daily lives. Of these lifestyle changes, perhaps the single most important concerns transport.

282. In a report published in 1997, the British Medical Association confirmed the links between transport and health.[287] Evidence from the United States and Australia has also indicated that promoting walking can change lifestyles and improve health.[288] Many commentators have argued that a national transport plan could provide a useful tool to promote and facilitate active methods of transport. According to Living Streets, "regular walking as part of a daily routine is a viable option and involves only modest changes to lifestyle."[289]

283. Targets to increase walking and cycling within the fabric of everyday life have been set by successive governments but have totally failed. Levels of each activity have dropped to an extent which we find startling. As we have noted, levels of walking and cycling have fallen dramatically in recent years.

284. Published research from Bristol University and elsewhere using accurate measures of children's movement indicates clearly that most energy expenditure takes place when children walk to school, play out at break times and again after school.[290] Informal play seems to be more important than formal activity at least up until the teen years. Furthermore, this work shows that children are less active at weekends and in school holidays, indicating how important the school and its schedule of activities, not just formal PE and sport are to facilitating children's activity. **We believe that providing safe routes to school for walking and cycling, adequate and safe play areas in and out of school is very important in the battle against obesity.**

285. The Environment, Transport and Regional Affairs Committee in its report on *Walking in Towns* made a wide-ranging and cogently argued series of 25 recommendations.[291] These included:

- The Government should set targets to increase the level of walking.
- The Government should publish a national walking strategy.
- Planning procedures should give priority to walking.
- Conditions for the pedestrian should be improved by ensuring that walking routes are continuous, well-connected to key destinations and well-signed, and that where such routes meet major roads in urban areas, pedestrians have priority.
- Particular emphasis should be given to creating good routes to important facilities, including schools and rail and bus stations and bus stops.

287 BMA Board of Science and Education, *Road Transport and Health*

288 Ev 164 (Living Streets)

289 Ev 163

290 A C Cooper, et al, "Commuting to school: Are children who walk more physically active?", *American Journal of Preventative Medicine*, vol 25,4 (2003), pp 273-76 and K R Fox "Childhood obesity and the role of physical activity", *Journal of the Royal Society for the Promotion of Health* 124 (2004), pp 34-39.

291 Environment, Transport and Regional Affairs Committee, Eleventh Report of Session 2000-2001, *Walking in Towns and* Cities, HC 167, Summary of Recommendations

- More traffic-calming and traffic restraining measures should be introduced.

286. Our witnesses echoed many of these points. Tom Franklin for Living Streets suggested that there should be a pedestrian pavement run-off at every junction.[292] John Grimshaw, for SUSTRANS, gave the example of Hull to illustrate the dramatic impact of reducing traffic speeds in cities to 20 mph.[293] Hull has implemented over 100 zones with 20 mph speed limits and the total number of road crashes in the zones has been reduced by 56%. Crashes involving child pedestrians have been cut by 70%.[294]

287. **The measures proposed by the Environment, Transport and Regional Affairs Committee in its report *Walking in Towns* 2001 strike us as sensible and persuasive and we are sorry so little action has been taken to implement them.**

288. **Given the profound impact increased levels of activity would have on the nation's health, quite aside from the obvious environmental benefits, it seems to us entirely unacceptable that successive governments have been so remiss in effectively promoting active travel.**

289. The Department for Transport again suggested to us that it was aiming to publish a consultation for a national walking strategy this year. The Department for Transport set out an overarching transport strategy in its *10 Year Transport Plan* published in 2000. This put forward no targets to stop the deterioration of footways, which acts as a barrier to walking.

290. Tom Franklin for Living Streets had no doubt that the reluctance to introduce the strategy stemmed from political squeamishness:

> The problem is that the Government is almost embarrassed about promoting walking. I have to say that I think that this comes from the John Cleese sketch 25 years ago of the Ministry of Silly Walks. Since 1996 every Transport Minister has promised a national walking strategy and every one has failed to deliver … They have not delivered because each time they get cold feet because they think they are going to be perceived as the Minister for Silly Walks.[295]

291. The Department for Transport representative giving evidence to us was tentative about progress, telling us that a document would be forthcoming imminently, but that rather than a strategy this would be a consultative 'document' containing some proposals.[296] The Department organised a series of seminars, then announced a consultation in the document *On the Move by Foot.* That paper, which is extremely slight, encloses a separate report prepared by Transport 2000, not by the Department. The consultation closed in September 2003 but as yet no strategy has been put in place.

292. **We regard the failure of the Department for Transport to produce a National Walking Strategy over a period of almost ten years as scandalous. This very inactivity**

292 Q499

293 Q499

294 www.transport2000.org.uk/news

295 Q503; the 'Silly Walks 'sketch was actually broadcast on 15 September 1970.

296 Qq144-48

clearly demonstrates that the priorities of the Department lie elsewhere. We would be extremely disappointed if concerns about political embarrassment had indeed obstructed such an important policy. One way of defusing any political embarrassment would be to incorporate the walking strategy into a wider anti-obesity strategy.

293. Assessing the precise contribution that walking can make to combating obesity is difficult, but we have been greatly struck by the potential of pedometers to increase awareness of sedentary behaviour and thus promote activity. The Department of Health is working in partnership with the Countryside Agency and the British Heart foundation to part-fund a targeted pilot project which will distribute pedometers to PCTs in areas of high deprivation as a motivational tool to encourage increased walking. This builds on the Countryside Agency's Walking the Way to Health initiative.[297]

294. Pedometers, which are small and inexpensive electronic devices used to count the number of steps a person takes in a day, can be a very useful tool for encouraging people to live more actively. According to Tom Franklin, "people only have to wear them for a week or so before they start to get a pattern of their exercise and they start to consider, if they did that slightly differently, what the effect would be."[298] The promotion of walking plays a key part in America's strategy to combat obesity, the America on the Move initiative being piloted in the Colorado on the Move scheme.

295. Launched in October 2002, Colorado on the Move is a state-wide initiative aimed at combating obesity.[299] It has programmes to increase physical activity in schools, worksites and communities. Pedometers are distributed to help participants monitor and increase physical activity. The aim is for participants to increase their daily walking by 2,000 steps per day. It is interesting to note that, so relentless has been the rise in obesity in the USA, the goal of Colorado on the Move is not to *reduce* the weight of the population but rather merely to *stop the weight gain*. The programme is now being modified to include dietary advice.

296. So far, over 75,000 people have participated in the scheme, ranging from public sector employees, to private companies, churches and native American Indian tribes. In two pilot projects based in communities with high-risk populations in Colorado, average increases of 2,000 steps have been achieved. Within schools, children are being encouraged to make use of the pedometer data within other lessons, for example by marking the total steps taken on a map and seeing how far they have travelled.

297. In America we ourselves were given Coca-Cola pedometers, and Colorado on the Move has sponsorship from a variety of commercial sources including Pepsi. We were told that Kellogg's was considering issuing pedometers.[300] McDonalds has also very recently announced a plan to distribute pedometers with Happy Meals in 2004 in England.[301] We believe that there is great potential for pedometers in making people more aware of their

297 Ev 15

298 Q503

299 Information in this section is sourced from Colorado Department of Public Health and Environment, *Colorado Physical Activity and Nutrition State Plan 2010*.

300 Q877

301 *The Daily Telegraph*, 23 April 2004

general activity levels and giving them an incentive to increase these. However, the mere issue of pedometers is unlikely to do much to address the problem. People need to be told how to use them, know what targets are desirable, and learn to make increased activity a life-time habit rather than a temporary goal. **We believe it would be helpful if commercial firms issuing pedometers also issued guidance agreed with Sport England and the FSA, on the recommended activity levels per day and on the correlation between steps taken and calories consumed.**

298. If bought in bulk, simple pedometers are very inexpensive and we can envisage a range of possible providers. These could include:

- Schools, who could keep sets of pedometers for use with different classes at different times. As in Colorado, pedometer data could be incorporated into other areas of the curriculum besides PE.

- Employers, who could issue pedometers to their staff, possibly even offering incentives for their use.

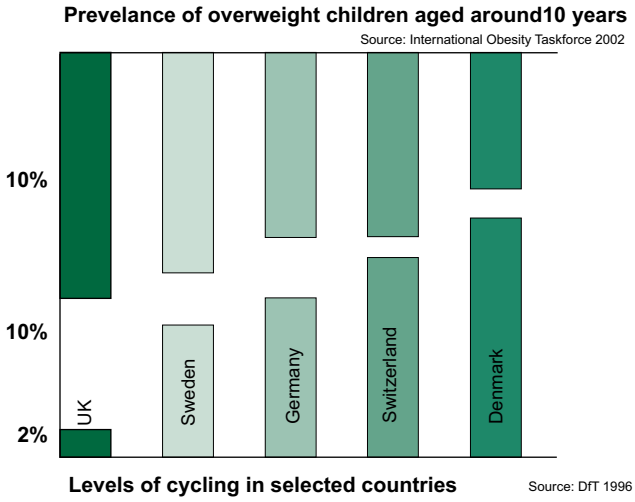
- GP practices, who could offer targeted advice to individuals, and use pedometers to help address the causes rather than the consequences of obesity which is what they largely treat now.

299. **We welcome the funding the Department of Health has provided to a pilot project on the use of pedometers. We recommend that the Department co-ordinates inter-departmental activity with a view to achieving wide-spread use of pedometers in schools, the workplace and the wider community.**

300. A number of witnesses pointed to the contribution they believed that cycling could make in combating obesity. The English Regions Cycling Development Team argued that there was a suppressed demand for cycling as there are more than 20 million bicycles in the UK, many of which were rarely used.[302] Sustrans suggested that countries which were broadly socio-economically similar to the UK but with much higher cycling rates had lower levels of obesity, as this graphic demonstrates:

302 Appendix 60

Figure 1: Correlations between levels of cycling and prevalence of overweight in selected European countries



Source: Sustrans, Ev 162

301. They contended that obesity was a symptom of the way the physical environment was planned and argued that changes should be made to encourage and facilitate active forms of travel, such as higher parking charges and improved cycling routes. In a survey of users of their National Cycle Network, 70% stated that the existence of the route had helped to increase their level of physical activity. Many of the proposals put forward by Sustrans could also link with attempts to improve healthy routes to school.[303] The Office of the Deputy Prime Minister therefore has a role to play in encouraging or demanding that town planning guidance includes measures to encourage physical activity.

302. The Department for Transport published a National Cycling Strategy in July 1996 with the target of increasing the number of cycle journeys four-fold by 2012. As part of the strategy a leaflet was published offering guidance to employers on ways to encourage their employees to cycle to work. It also referred to the co-ordination role that local authorities could play in stimulating changes to make cycling an attractive means of travel to work for more people.

303. The leaflet suggests a number of measures that employees could take to encourage cycling to work, including the provision of safe, secure and covered cycle parking, lockers, changing/drying facilities and showers and the offer of interest-free loans to purchase bicycles. The Department for Transport also pointed out the benefits to employers of this policy. By having a fitter, healthier workforce, employees will take fewer sick days and will have improved levels of concentration.[304]

304. The *10 Year Transport Plan* was published in 2000. This included an ambitious target to treble the number of cycling trips between 2000 and 2010. It provided additional funding to make conditions easier and safer for pedestrians and cyclists. The *Plan* requires authorities to prove, through Local Transport Plan (LTP) Annual Progress Reports, that

303 Ev 161

304 Department for Transport, *Cycling to Work*, 2001

they are developing and implementing strategies to secure significant increases in cycling and walking. Over the five-year period of the first LTPs, local authorities estimate they will deliver over 5,500 km of new or improved cycle tracks and cycle lanes. Around 1,200 km of cycle tracks and lanes were laid by local authorities in 2001-02 an increase of 43% on the previous year. In the same five-year period LTPs estimate that they will deliver over 1,000 km of new or improved footways and pedestrianisation schemes.

305. In 2002 two initiatives were launched by the Department for Transport to help deliver increased levels of cycling. A National Cycling Strategy Board was set up to co-ordinate and monitor implementation of the National Cycling Strategy, supported by a network of regional advisers to promote good practice and provide support to local authorities. Additionally, a Cycling Projects Fund, with £2 million funding was launched in March 2002 to support projects that can achieve a significant increase in cycling locally, or raise public awareness of the increase in cycling opportunities.

306. However, in the progress report on the ten-year plan, *Delivering Better Transport* (December 2002), only two of the 150 pages are devoted to progress in encouraging cycling and walking. This report also admits that latest available data from the National Travel Survey suggest that, as of 2001, the long-term decline in cycling and walking had not been reversed.

307. In 2002, the then Transport, Local Government and the Regions Committee expressed "little confidence" that the target for cycling increases would be met, detecting few signs of any growth in cycling in the first two years of the period.[305]

308. CTC, the National Cyclists Association, suggested some additional policies that would be useful to increase the number of cyclists, such as integrating cycling with public transport by creating cycle carriages on trains and buses, providing cycle hire facilities and doing more to tackle the growth of traffic and reduce the need to travel.[306]

309. Countries such as the Netherlands and those in Scandinavia have seen a much slower increase in obesity rates in the last 20 years and this is generally attributed to those countries' inhabitants having a much more active lifestyle, and in particular greater opportunities for active transport. In countries where there have been steady increases in cycling, such as in Denmark, there has been a reduction in casualty rates per mile. This has been achieved by "adopting comprehensive measures to create better conditions for cycling and because the more cyclists that there are, the more motorists are aware of cyclists and consequently the better they are at dealing with them."[307]

310. Again, a Health Committee report is not the appropriate forum to discuss the detailed measures required to increase cycle use on a massive scale. We can, however, record some of the key points that our witnesses made. John Grimshaw for Sustrans suggested that "Mostly any cycle lane stops exactly where you want it, at the junction." He urged that pedestrianised city centres should be permeable to cyclists. He also suggested that greater priority should be accorded to cyclists, for example by making one way streets two way for

305 Transport, Local Government and Regions Committee, Eight Report of Session 2001-02, *10 Year Plan for Transport*, HC 558, para 104

306 Appendix 8

307 Appendix 60

cyclists, as was common on the Continent.[308] Employers could play their part by ensuring that there were adequate cycle parking facilities and showers and changing rooms available.

311. Denmark is a country with some of the highest cycling rates in Europe, and cyclists are given much more priority in transport planning. We visited Odense, Denmark's third largest city, which has a population of 200,000. The Danish Department for Transport has nominated Odense as Denmark's "national cycling city." Cycle use rates are extremely high. In Odense we met local urban planners to see what made the city so appealing for cyclists.

312. It was immediately obvious that cyclists were granted a far higher status in this city than in any in England. Dedicated cycle paths, screened from cars and pedestrians, allowed cyclists access to all of the city centre. A covered cycle parking space with room for 400 cycles had replaced a car park which had accommodated eight cars. It was even possible, for a small fee, for people to lock a cycle and any valuables away in a secure automated garage facility. As in all Denmark, there is a presumption that liability for an accident involving a motorist and a cyclist lies with the motorist. This is not the case in English law.

313. The sophisticated and comprehensive cycle network we witnessed had not been designed into Odense—this is an historic city, with a cluttered centre made up of eighteenth- and nineteenth-century buildings. It has had to be integrated within an existing city, as would be the case with major towns and cities in England. We were told that the current configuration for cycling was actually the third phase of planning. For almost 20 years Odense has been working to develop cycling. We were particularly impressed to see how children were involved in the planning process. Each year, children in schools are asked to use a computer program to map their journey to school. On this, they mark any hot-spots where they feel in danger. This information is then collated and planning authorities give priority to improving conditions at these danger spots. We also commend the approach we saw in Odense, where funding support for school transport was based on the degree of danger in covering the route from home to school by other means. This provides a financial incentive on the authorities to create safer walking and cycling routes.

314. We are pleased to note that the Department of Health has recently been involved in active travel plans. According to one of our witnesses, it was essential that the Department should have an input into transport policy; for this witness at least, that had not always been the case:

> The Department for Transport has this target of increasing cycling four-fold to eight per cent of all journeys, which would more or less be in common with what was achieved in Sweden. I am sure that the Department of Health have not put their weight behind that; they probably do not even know it exists. Yet a four-fold increase in cycling would probably be more valuable for their aspirations than for the Department for Transport which is actually only interested in reducing congestion.[309]

308 Q502; 509

309 Q563 (John Grimshaw)

315. The Department for Transport has recently announced that it will provide funding for "sustainable travel towns". It has set aside £10 million to help develop plans for sustainable transportation in three towns in England. These towns will "incorporate all aspects of best practice to encourage walking, cycling and other public transport use and act as showcases for other towns wishing to promote greater travel choice." Darlington, Peterborough and Worcester were selected from applications by 51 local authorities who submitted expressions of interest. They were selected on the basis of fully worked-up plans to deliver a sustainable transport scheme aiming to produce innovative school, work and personal travel plans; cycle lanes and improved cycle parking; better conditions for walking; and improved bus services.[310]

316. **It would not be appropriate for us to spell out the individual measures required to achieve the Government's ambitious cycling targets, although we were particularly impressed by the segregation of cyclists from road traffic we witnessed in Odense. If the Government were to achieve its target of trebling cycling in the period 2000–2010 (and there are very few signs that it will) that might achieve more in the fight against obesity than any individual measure we recommend within this report. So we would like the Department of Health to have a strategic input into transport policy and we believe it would be an important symbolic gesture of the move from a sickness to a health service if the Department of Health offered funding to support the Department for Transport's sustainable transport town pilots.**

317. As the submissions from Living Streets and SUSTRANS made clear, what is needed is a wholesale cultural change to a country where people are more active. Town planning needs to prioritise pedestrians and cyclists rather than road vehicles; a strip of white line at the side of a busy trunk road does not constitute a safe cycle route.

318. Sustrans, in partnership with the Children's Play Council and Transport 2000, has supported Home Zones schemes, where groups of streets are designed and laid out so that car users do not have priority over other users, with cars travelling at little more than walking pace. The design enables people to use the streets as a social space, meaning that children can play outside, neighbours can socialise and the local communities can take control of their own environments.[311]

319. There are other impediments to active travel in addition to the transport network and services. Services located in out-of-town sites where access is only easy by car promote a sedentary lifestyle and "help 'lock-in' car dependence."[312] The Social Exclusion Unit's report into transport and social exclusion indicated that from the mid 1970s to the late 1980s, total distance travelled for food shopping increased by 60%.[313] Whilst transport policies are necessary and important, the wider planning of communities also needs to change. There seem to be no regulations in place requiring active travel and recreation opportunities for all new housing developments; these are still being built with no consideration of the need for safe walking and cycling routes to school.

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310 Department for Transport News Release 2003/0172

311 Ev 111

312 Ev 111

313 Ev 164 (Living Streets)

320. Many commentators argue that a national transport plan would be useful to promote and facilitate active methods of transport. Sustrans contended that obesity was a symptom of the way the physical environment had been planned and that therefore they would like to see changes that encouraged active forms of travel, such as higher parking charges and improved cycling routes. Sustrans, the National Heart Forum, the International Obesity Taskforce and others argued that a health impact assessment should be made on all transport project proposals and policies before implementation.

321. **There will be profound economic as well as health costs to be paid if the current obesity epidemic continues unchecked. Major planning proposals and transport projects are already subject to environmental impact assessment; we believe that it would be appropriate if a health impact assessment were also a statutory requirement. This would enable health to be integrated into the planning procedure and help bring about the sort of creative, joined-up solution which is required. This may seem a cumbersome and drastic step but we believe that only such strong measures will help reverse the dramatic decline in everyday activity that has occurred in recent decades.**

The workplace

322. Employers also have a role to play in encouraging activity. We were surprised not to receive a single memorandum from any industry not directly involved in obesity, or any umbrella organization representing the interests of industry, in the course of our inquiry. The problems of overweight and obesity are already having a substantial impact on business. For example, back pain is the largest single cause of days lost from work; obesity is a known contributor to back pain, as is a general lack of fitness.

323. Our predecessor Committee, in the course of its public health inquiry, visited Cuba, a country with remarkably good health outcomes given its relatively tiny health expenditure as compared with the UK.[314] One of the features of public health in Cuba is the extent to which workplaces encourage employees to take part in physical activity. It is true that there are isolated examples of similar practice within England, but they are the exception rather than the rule.

324. Sport England suggested that tax incentives could be provided to employers that provided gym membership to their staff.[315] We believe that this is an area that could be explored but we also recognise that there are many simple measures that could be taken to raise the energy output of employees at work. The NAO report *Tackling Obesity in England* noted the example of research by Glasgow University and Glasgow Health Board which aimed to test "whether incidental activity could be incorporated into the daily routines of members of the public." Simply by putting signs on the escalators encouraging stair use to maintain fitness, stair use increased by 15–17%.[316]

325. The settings for heating and air conditioning in offices affect the amount of energy the body uses. Commercial canteens, like schools, can provide healthy or unhealthy food; simply offering better information on, for example, the calorie content of different meals

314 Health Committee, Second Report of Session 2000-01, *Public Health*, HC 30, para 21

315 Appendix 19

316 *Tackling Obesity in England*, p 35

might offer a start. As we have already seen, employers can make cycling, walking or running easier for their employees by offering appropriate facilities.

326. Little seems to have been done to address the problems of sedentary behaviour in the workplace. Yet, as the working patterns of modern society have drastically altered, and as manual labour has dwindled, the office-bound workplace, with its desk, chair and computer terminal has become the norm for millions of people.

327. In the USA, one major company, Sprint Telecoms, has recently opened a 200 acre headquarters building designed to make its employees lose weight by forcing them to walk everywhere. The car parks have been built ten minutes walk away from the offices; staircases are airy and inviting; the lifts are slow and small. Sprint argues that reducing obesity will reduce absenteeism and improve the performance of its employees.[317]

328. **We recommend that the Department of Health, in conjunction with the Department for Work and Pensions and the Department of Trade and Industry first organises a major conference to promote awareness of obesity in the work-place and then engages in an ongoing process of consultation to see how measures can be taken to address sedentary behaviour. We recommend that these Departments consult with the Treasury to see what fiscal incentives can be provided to promote active travel.**

329. **We also recommend that the public sector looks to set an example in finding creative ways of encouraging activity in everyday life, and that this is built into a PSA target for each Department.**

Strategic direction

330. Some memoranda queried whether adequate structures existed to promote and implement measures to facilitate healthy lifestyles. Len Almond from the BHF National Centre for Physical Activity and Health called for a much-needed strategic platform to promote physical activity which would involve an alliance of interested organisations to plan the direction and lead on strategy.[318] He suggested: "at present there is no organisation that represents the interests of mass participation in health promoting physical activity in England. Consequently, there are no national strategic plans to promote physical activity for health."[319] It is clear however that in order to increase levels of physical activity, policies must make it easier for people to be more active as part of their daily routine—primarily through promoting active transport—and must encourage people to be more active in their recreation time.

331. Our predecessor Committee's report into *Public Health* recommended that the Government should appoint advisers to co-ordinate the work of all departments in delivering the sport and health agenda. The Government rejected this proposal but partly in response to our recommendation, and following findings in *Game Plan*, an Activity Co-ordination Team (ACT), was created and co-chaired by the Minister for Public Health and the Minister for Sport, with senior representatives from the following Departments:

317 "Architects join fight against the flab", BBC News website, 27 March 2003.

318 Ev 106

319 Ev 103

Health; Culture, Media and Sport; Education and Skills; Environment, Food and Rural Affairs; Work and Pensions; Office of the Deputy Prime Minister; Home Office; and Treasury. In addition, there were representatives from No. 10 Downing Street, Sport England, the Local Government Association, the New Opportunities Fund and the Health Development Agency. There was an interval of almost seven months between the recommendation in *Game Plan* that a board co-ordinating activity should be created, and the first meeting in July 2003 of the ACT. As we write this report it has met on five occasions.[320]

332. The practical steps it is hoped ACT will take will be to:

- Innovate, introducing change where there is supporting evidence and available funding—this should give early impetus to the work.
- Pull together evidence and present it—jointly with outside sporting and health organisations—as part of a positive communication strategy, disseminating evidence and best practice.
- Test and evaluate interventions where evidence is not strong, including external factors relating to increased participation, such as crime reduction—where the timescale might be longer.
- Identify sources of funding.
- Gather comprehensive data on participation and fitness regularly.[321]

333. The ACT, we were told, will produce "a three-year delivery plan by Spring 2004" which will seek to drive up mass participation. The ACT will present a progress report of its work later this year. In addition to this, the Department of Health is working to establish nine Local Exercise Pilots based in PCTs, whose aim will be to test different community approaches to increasing levels of and access to physical activity. The Department of Health pointed to a number of initiatives showing fruitful joint working between departments, such as the Healthy Schools initiative (joint Department of Health/Department for Education and Skills) and the Young People's Development Pilot Programme.

334. **We welcome the creation of the Activity Co-ordination Team though we regret it took so long for it to begin its work. Anything that co-ordinates Government activity in this complex and challenging field is worthwhile. We await with interest the publication of its first report. We recommend that its reports explicitly link its activity to the Government's specific targets on activity both in schools and in the community.**

320 HC Deb, 30 March 2004, col. 131 W

321 www.culture.gov.uk

The role of the NHS

Prevention of obesity

335. Prevention must clearly be the primary focus of any efforts to address the problem of obesity, as we have received compelling evidence suggesting that obesity, once established, is extremely hard to treat.[322] Much of the written evidence we received supported a policy focus centred on prevention, with the National Heart Forum arguing that "on the basis of current evidence and technologies there is very limited scope to reverse or 'cure' obesity in individuals."[323] We hope that the recommendations set out above will enable people to make healthy lifestyle choices, and that in turn these choices will allow trends in overweight and obesity to be stabilised in the short term, and reversed in the long term. However the health service clearly has an important role to play in backing up these environmental measures with explicit support for prevention.

336. PCTs, as well as commissioning health services for their local populations, have an explicit role in improving public health. To this end, we might have expected to receive evidence of a number of community-based initiatives geared to preventing obesity. However, we were struck in this inquiry, as in our inquiry into S*exual Health*, by the fact that we received very little evidence on strategic prevention within the NHS. In fact, we received only one memorandum from a PCT public health lead, and none at all from Strategic Health Authorities, despite their responsibility for overseeing the delivery of public health services for the whole of their areas.

337. When we asked Department of Health officials how many PCTs currently had an obesity lead actively working on tackling the problem in their local area, they were not able to answer. **The Department agreed that Strategic Health Authorities (SHAs) should have information about local work on obesity at their fingertips, and we recommend that a survey of action on obesity, both at PCT and SHA level, should be undertaken as part of the ongoing work on the forthcoming White Paper on public health.**

338. A recent report by the independent health information organisation, Dr Foster, showed that strategic action on obesity seemed at best patchy:

> Although most Primary Care Organisations (PCOs)[324] had some form of publicly stated policy with regard to obesity, there was enormous variation between areas with some having highly developed policies, whilst in other areas the issue was given relatively little emphasis.
>
> Most PCO policy on tackling obesity is framed in the context of tackling CHD. The analysis of Local Development Plans showed that 30% of areas had well developed strategies in this area.
>
> In some areas, there was little more than a passing mention of obesity in Local Development Plans. For example, Harrow PCT has no detailed obesity strategy,

322 For example, see Appendix 33 (Dr Sheila McKenzie).

323 Ev 113

324 Including Primary Care Trusts, Local Health Boards in Wales and Scotland, and Health and Social Services Boards in Northern Ireland.

> neither is obesity tackled specifically in its action plan for CHD … Cambridge City PCT also makes no reference to the prevention or treatment of obesity within other identified areas for action, e.g. CHD.[325]

339. Amanda Avery, a community dietician with Greater Derby PCT, told us that within PCTs there was not necessarily the flexibility needed to tackle the problem of obesity. She argued that:

> Drug budgets could be considerably reduced if obesity was better addressed. Unfortunately, it is quite difficult to transfer monies from a PCT's prescribing budget to help fund other initiatives to address obesity. All the emphasis is currently on guidance as to how to use drugs but not on guidance as to how to prevent their use in the first instance.[326]

340. Ms Avery also suggested that the structural changes in the NHS in recently years had led to difficulties around partnership working with other organisations:

> People who championed the obesity cause perhaps moved on. Within our PCT there are good examples of partnership working, but continuity is required over a number of years to establish good outcomes.[327]

341. The failure of PCTs fully to embrace the public health agenda seems also to be reflected more widely. Melanie Johnson told us of her view that there needed to be "fuller development of public health at the PCT level",[328] and the recent Wanless report also made several remarks in this area. It firstly highlighted the "disruptive impact" of the recent reorganisation of NHS structures on public health, arguing that the size of PCTs, and the capacity and dispersal of the public health workforce, had led in some areas to insufficient "critical mass" to fulfil public health responsibilities.[329] The creation of 303 PCTs from 95 Health Authorities has meant that public health resources within each PCT are now considerably smaller, and an increase in corporate responsibilities for each Director of Public Health has resulted in "a reduction in their ability to undertake and practise public health work."[330] Public health teams are now much smaller than they were previously, and with relatively high vacancy rates, many PCTs now 'share' their Directors of Public Health.

342. Derek Wanless reported "A survey commissioned by the Department of Health in 2002–03 to identify the capacity and development needs of PCT and Strategic Health Authorities found that the Specialist public health workforce was thinly distributed and unequally spread"[331], and some PCTs reported that the support provided for public health by SHAs was "variable"[332]. To counter these problems, he recommended that the Department should "reinforce the role of SHAs in relation to the performance

325 Dr Foster, *Obesity Management in the UK*, available at www.drfoster.co.uk.

326 Ev 351

327 Q 1101

328 Q1299

329 Derek Wanless, *Securing Good Health for the Whole Population*, Final Report, HM Treasury, February 2004

330 Ibid, p 45

331 Ibid, p 45

332 Ibid, p 49

management of the public health function within PCTs", and also that the Healthcare Commission "should develop a robust mechanism for the performance assessment of the public health role of PCTs and SHAs."[333]

343. **We feel strongly that Primary Care Trusts should be taking a more active role in preventing obesity, and urge the Government to ensure that PCTs have the capacity, competency and incentive to fulfil their crucial obligation to safeguard the public health of the local communities they serve. We also endorse the recommendation of the Wanless report that the Healthcare Commission should develop a robust mechanism for assessing performance of both PCTs and Strategic Health Authorities with respect to public health.**

Treatment of obesity

344. Dr Nick Finer, a consultant in obesity medicine at Addenbrooke's Hospital, Cambridge, stressed to us that "even the most successful prevention policies cannot address the current burden of ill health related to obesity, nor obviate the need now, or in the future, for appropriate medical care for the obese."[334] However, when we asked about the provision of such services, we were informed by the Department that the responsibility for ensuring provision of obesity services rested exclusively with PCTs. Worryingly, it was not only in strategic action to prevent obesity that PCTs, and the NHS more broadly, appeared to be failing. The evidence we received pointed repeatedly to the gross inadequacy of services currently available to tackle obesity within the NHS, as articulated by Dr Ian Campbell, a GP with a special interest in obesity:

> Whilst no-one would disagree that it is important to prevent obesity, particularly among children, I just find it inconceivable that we should reach a situation where we are not able to offer treatment to those who are already obese, which is about 10 million people.[335]

345. Sally Hayes, of North West Leeds PCT, described the current situation in even more stark terms, contending that "at present most of the NHS has no systematic approach for the management of obesity at any level of BMI."[336]

346. The problems appear to have originated with a lack of prioritisation within PCTs, and to have filtered through every level of service provision. TOAST argued that the vast majority of PCT teams were unaware of their obese patients and "frankly uninterested and unaware of the aetiology of the problem."[337] This view was supported by Roche, who maintained that there was "little motivation within PCTs to ensure that weight management is offered to patients" since obesity is seen as a "lifestyle" not a medical issue.[338] The Dr Foster research showed that over half of primary care organisations in the UK did not have organised weight-management clinics within their local areas, and even in

333 Ibid, p 50

334 Ev 329

335 Q1046

336 Ev 354

337 Ev 372

338 Appendix 6

those areas that did, such clinics were available on average through only a quarter of GP practices. According to Roche, "obesity does not rank very highly as an area of interest to GPs", a view which was re-emphasised by Sally Hayes:

> At present, primary care professionals are offering short term support to people who are obese within current resources which may include diet, activity and behavioural strategies. Unfortunately this is often on an ad hoc basis with little structure to these key interactions.[339]

347. Obesity is a complex medical problem, and it is clear that superficial interventions, such as the distribution of a diet sheet to an obese patient, are unlikely to work. Specialist skills and knowledge are needed fully to engage with obesity as a psychological and behavioural as well as a physiological problem. It has been likened by some to alcoholism, and requires similarly holistic treatment programmes.

348. Professor John Baxter, a consultant bariatric surgeon, described his constant amazement at the fact that other doctors referring patients to him for bariatric surgery appeared to know so little about obesity, and evidence from those actually working in primary care supported this view. Louise Mann, a practice nurse at the Gable House Surgery in Wiltshire, told us that "as nurses, we do not get any training at all in weight management in our training. In primary care and with our practice, we did weight management, but very much in an *ad hoc* way, with no instruction at all."[340]

349. This is perhaps particularly concerning given that many of our witnesses were in agreement that primary care was the best level at which to tackle obesity. The National Obesity Forum argued that the "vast majority of overweight and obese people are encountered within primary care, either seeking help directly for their weight problem, or indirectly because of a related medical condition", and maintained that primary care was the best place to offer intervention and concentrate funds and efforts.[341] And according to Colin Waine, Visiting Professor of Primary Care at the University of Sunderland, "about 75% of the population see their general practitioner in one year and approximately 90% over a five-year period. Thus the opportunities exist to identify opportunistically people at high risk and likely to benefit" from treatment. Dr Waine went on to argue that this was in fact one of the great strengths of the British system of primary care.[342] Research commissioned by Roche suggested that patients were reluctant to discuss their weight pro-actively, and would prefer their health care professional to raise the issue. However, further research found that general practitioners were unlikely to raise the issue of obesity during a health consultation.[343]

350. The Counterweight project, a pilot obesity management study being trialled in 80 general practices, is attempting to evaluate the usefulness of setting up specialised obesity-management clinics within a general practice setting, following specialised training and using tailored protocols. The clinicians, who do not necessarily need to be GPs, follow

339 Ev 354

340 Q1082

341 Ev 318

342 Q1063

343 Appendices 6 and 7

protocols setting out different evidence-based 'lifestyle approaches' to obesity management. The programme will be fully audited in each practice after two years, and will measure changes in clinician knowledge, attitudes, perceived confidence and willingness to treat obesity, as well as changes in practice approaches to obesity management and weight-screening rates. The primary end point for the patient intervention programme will be the percentage of patients achieving ≥5% and ≥ 10 % weight loss. While the final conclusions of the programme will not be known for some time, the preliminary results from the intervention programme indicate that clinically beneficial weight loss can be achieved in high-risk obese patients in the primary care setting.[344]

351. However, service providers maintained that resources to provide structured, long-term interventions to tackle obesity in primary care were simply not available. Dr Campbell felt that GPs would be "up in arms" if they were instructed to institute routine measurement of BMI, and stated categorically that there was no point in measuring BMI without sufficient resources to address obesity where it is identified:

> To try to put this into context, my own practice is 4,500 patients, and we have identified 483 who are clinically obese. I could not start to treat all of those tomorrow, so just measuring it is one thing. You need therefore the resources to do something about it.[345]

352. The Counterweight Project told us that it deliberately did not give practices extra funding, relying, in the words of a practice nurse, "on the good will of GPs".[346] We also heard how a 15-month project to develop a service for weight management within four GP practices in the Leeds North West area also risked being abandoned as it could not secure ongoing funding.[347]

353. In contradiction of the Public Health Minister's argument that the new GP contract provided sufficient incentives for health promotion, Dr Campbell told us that out of a possible 1,000 quality points GPs could gain, only three could be acquired by measuring body mass index.[348] None related purely to the treatment of obesity. Dr Campbell characterised this failure of the new GP contract to incentivise GPs to treat obesity as a significant mistake.

354. Our witnesses argued compellingly that improving obesity services within primary care was not an aspiration that was entirely out of reach. Dr Campbell suggested that programmes to train primary care clinicians in obesity management, like the Counterweight project and that being undertaken by Leeds North West PCT, would not need to be extended to all primary care practices, but that targeted training need only be offered to interested GPs. Trained GPs with a specialist interest in obesity could then provide specialist obesity services within their own practices, and other practices could also refer to them, as an intermediary between primary and secondary care.

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344 Ev 344-46

345 Q1064

346 Q1077

347 Q1084

348 Q1066

355. **We feel that this country's well developed network of primary care providers, local GPs, provides a unique resource for health promotion and for the identification and management of patients who are overweight or obese. However, managing weight problems sensitively and successfully requires specialist skills, and we are concerned by suggestions that obesity is viewed by many clinicians as a lifestyle issue rather than a serious health problem requiring active management to prevent dire health consequences. We deplore the low priority given to obesity by the new GP contract. We hope that NICE guidance on the prevention, identification, evaluation, treatment and weight maintenance of overweight and obesity, currently expected in Summer 2006, will go some way towards increasing the priority of obesity within general practice, as well as helping primary care practitioners develop and improve the services they provide in this difficult area. The Government should also ensure that within each PCT area there is at least one specialist primary care obesity clinic, probably supported by a range of different health professionals, to which GPs can refer any patients they identify as needing specialist support to address a developing or existing weight problem.**

356. Weight management within primary care may not necessarily need to take place in traditional primary care settings such as the GP surgery, or even be carried out by GPs. The majority of practices in the Counterweight project, for example, ran nurse-led clinics under the supervision of a GP. Community dieticians can also play an important part, and organisations representing community pharmacists have submitted evidence stating that they are keen to play an increased role in dealing with obesity; and that they have developed thinking in this area, building on an existing scheme for diabetes testing.[349] In Finland we noted moves to make testing for diabetes available in a much wider range of settings. **We recommend that, in establishing primary care obesity clinics, PCTs should fully explore the possibilities of using less traditional models of service delivery, involving clinicians from across the professional spectrum, from nurses to pharmacists to dieticians. The full range of interventions available to treat obesity includes diet, lifestyle, medical treatment and surgical treatment.**

357. **We also took some interesting evidence from commercial slimming organisations. We recommend that the NHS examines whether their expertise can be brought to bear in devising strategies to combat obesity holistically.**

358. Although primary care provides the best starting point for treating people with weight problems, more specialist care is clearly necessary for some patients, particularly those with severe and complex problems relating to their obesity, including, amongst others, patients with metabolic and cardiovascular disease whose treatment will need to involve an holistic approach to their medical needs; those suffering from sleep apnoea syndrome; those requiring peri-operative care where weight loss may be needed to minimise risk and optimise outcome; and those with life-threatening morbid obesity.

359. The evidence we received universally pointed to a dire lack of specialist obesity care provision in the NHS. Sally Hayes, of North West Leeds PCT, stated that currently "the secondary care service for morbid obesity has a closed waiting list."[350] Dr Nick Finer, a

349 Appendix 26 (The Pharmaceutical Services Negotiating Committee); Appendix 31 (Lloydspharmacy)

350 Ev 354

consultant obesity physician, argued that "secondary care cannot effectively contribute to the management of obesity since it hardly exists."[351] Interestingly, we heard that there have in fact recently been specific directives aimed at the treatment of obesity in secondary and tertiary care. Services for morbid obesity were defined in the Specialised Services National Definitions Set (2nd Edition) No. 35, released by the Department in December 2002. These identified specialised treatment activity that should be subject to collaborative commissioning arrangements including: "an integral management approach … aimed at weight loss and weight maintenance … drawn up by a multi-disciplinary team to meet the needs and requirements of each individual patient." However, Dr Finer argued that in his own area of Anglia, as well as elsewhere in the UK, "these services remain unimplemented, with no process or individual responsible for their implementation as yet operational."[352]

360. Dr Finer reported that the existence of both of the clinics he ran had always been dependent upon research funding, and that both clinics struggled "to receive explicit funding from Primary Care Trusts."[353] He also described the significant mismatch between demand and capacity. At his Luton clinic, he could see about 250 new patients a year. At Addenbrooke's the capacity was only 80 new patients a year. However, the clinics regularly received five times as many referrals as this, and even this figure did not take account of a vast amount of untapped demand. Dr Finer estimated that the current prevalence of obesity meant that within the catchment area of a typical hospital serving a population of 300,000, about 130,000 adults would be overweight or obese, 53,000 obese (BMI>30), and about 3,500 morbidly obese (BMI>40). This means that even if specialist obesity treatment were only to be offered to all patients with morbid obesity, Dr Finer's clinic would require a 14-fold increase in capacity.[354]

361. Oversubscription to the clinic recently forced Dr Finer to run 'group' consultations, which were not well received by patients, and also, more worryingly, to close his clinics to new patients when waiting lists got too long:

> The problem has always been how to meet the demand which is there, with the lack of resources. At Luton … over the last seven or eight years the only way of managing referrals was to shut the clinic to referrals. I have been at Addenbrooke's now full-time for a year, and I run a clinic that is primarily resourced from my appointment as a university appointment. Without my doing a large number of extra clinics to see these new patients, I would have lost Addenbrooke's Hospital its third star probably six months ago.[355]

362. The Department told us that there were only ten obesity clinics in England, and that these were not evenly distributed.[356] According to Dr Finer, all of these clinics had waiting lists of "at least 12 months".[357] To put this in context it is worth noting that the

351 Ev 329

352 Ev 329

353 Ev 328

354 Ev 329

355 Q1047

356 Q60

357 Q1051

Government aims to achieve a maximum wait of three months for an outpatient appointment in any specialty by 2005, and interim targets for March 2004 were set at no more than four months for an outpatient appointment.[358] However, when discussing with us the number and availability of specialist obesity clinics, Department of Health officials did not seem concerned about the low numbers, and stated that "whether there should be more is a decision that needs to be taken through PCTs in consultation with other local commissioners as to the need."[359]

363. **Obesity is a serious medical problem. Although in common with other illnesses, its prevention and some first-line management can be delivered within a primary care setting, patients with more entrenched or complex problems need prompt access to specialist medical care. Childhood obesity is a worrying and increasingly common subset of this illness, and children in particular need specialist care. Yet specialist obesity services seem to be an almost entirely neglected area of the NHS, apparently exempt from Government initiatives to push down waiting times despite their obvious importance in preventing a large range of other debilitating and costly diseases. We therefore recommend that the Government provides funding for the large scale expansion of obesity services in secondary care, underpinned by careful management to ensure that the service provision is matched to need. The Government's maximum waiting time targets must apply to all of these services.**

364. The treatment of children with obesity is, if anything, more important than that for adults, as habits set down in childhood are likely to form the pattern for the rest of a person's life. However, Dr Finer told us that specialist services for obese children were "even patchier" than the virtually non-existent provision for adults, a view endorsed by Dr Mary Rudolf, a consultant paediatrician with a specialist interest in obesity:

> There is a dire lack of services within the NHS for the management of childhood obesity. Our experience in Leeds is likely to be typical of the rest of the country. There is no specialist service even for the grossly obese. A minority of these children are seen in the Regional Endocrinology Service (and only if they are likely to have medical problems resulting from their obesity). They are seen briefly and only very periodically for a "medical check" but no real intervention. The hospital paediatric dietetic department is so limited that there is a ruling that no child may receive dietetic advice about their obesity even if they are on medication for the problem. [360]

365. In June 2003 the waiting list for the specialist obesity service for children at Bart's and the London Trust stood at 11 months and rising.[361]

366. **We were appalled to learn of the desperate inadequacy of treatment and support services for obese children. Steps must be taken to ensure that obese children and young people have prompt access to specialist treatment wherever they live.**

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358 *Improvement, Expansion and Reform – the next three years – Priorities and Planning Framework 2003-2006,* Department of Health

359 Q60

360 Ev 329; Appendix 4

361 Appendix 33

367. Recent research carried out by the Peninsula Medical School has suggested that overweight and obesity are now becoming so commonplace amongst children that even parents are failing to notice when their own children become overweight or obese. In a survey of 300 British families, only 25% of parents with overweight children recognised that their children were overweight. No fathers identified their sons as overweight, even when they were, and, perhaps even more disturbingly, 33% of mothers and 57% of fathers described their children as 'normal' when in fact they were obese.[362] As treatment is only possible once a problem has been identified, this represents a worrying trend. We were also told by Professor Jane Wardle, of the Health Behaviour Unit at University College London, that parental concern about children developing eating problems may be overly biased towards eating disorders such as anorexia and bulimia:

> I think parents feel exceptionally responsible if their children develop eating disorders. I think probably they feel slightly less responsible if their children develop obesity, even though that may not be the justifiable allocation of responsibility.[363]

368. We feel that the school nursing system offers a valuable opportunity to correct this through a programme of routine measurement of BMI throughout a child's school career. The Children's Minister, Margaret Hodge, expressed reservations about the possibility that such a measure could stigmatise overweight and obese children. We are confident that this could be overcome, through the adoption of a sensitive approach whereby rather than singling out individuals, all school children are weighed and measured once a year, and their BMI results sent in confidence to their parents together with, if appropriate, advice on how to modify diet and exercise patterns. Not only would this system identify children who are already overweight or obese, but it could target those at the top end of the 'normal' range of BMI to prevent further weight gain. As the Public Health Minister reassured us that every school now had access to a school nurse, we are confident that such a scheme could be administered within existing resources.

369. **We recommend that throughout their time at school, children should have their Body Mass Index measured annually at school, perhaps by the school nurse, a health visitor, or other appropriate health professional. The results should be sent home in confidence to their parents, together with, where appropriate, advice on lifestyle, follow-up, and referral to more specialised services. Where appropriate, BMI measurement could be carried out alongside other health care interventions which are delivered at school, for example inoculation programmes. Care will need to be taken to avoid stigmatising children who are overweight or obese, but given that research indicates that many parents are no longer even able to identify whether their children are overweight or not, this seems to us a vital step in tackling obesity.**

370. The National Institute for Clinical Excellence (NICE) has published guidance supporting the use of the obesity drugs orlistat and sibutramine in certain, limited circumstances.[364] These drugs in no way represent a 'cure' for obesity, their success rate averaging a maximum of 5kg of weight loss per year of treatment, weight loss which is

362 *The Observer*, 14 March 2004

363 Q205

364 Nice Guidance No 22, Orlistat for the treatment of obesity in adults, 9 March 2001. Nice Guidance No 31, Sibutramine for the treatment of obesity in adults, 26 October 2001.

usually regained once treatment has stopped. For this reason, the conditions attached by NICE to use of these treatments stipulate that they must be supported by dietary and lifestyle changes. According to the Department's memorandum, estimated costs since the two products became available on the NHS are now approximately £31 million.[365]

371. Research carried out by Dr Foster concluded that 96% of PCTs were prepared to provide funding for drugs for the treatment of obesity, although 4% were not, despite the NICE guidelines. However, this does not necessarily provide a true picture of whether all patients who could potentially benefit from drug treatment are obtaining it, as this will depend on whether GPs are knowledgeable and confident enough to prescribe it, or whether patients are able to secure a referral to vastly over-subscribed specialist obesity clinics. Equally, although PCTs may have an official policy of funding the drugs, GPs may come under pressure to curtail their prescribing of obesity drugs to stay within cost limits, a situation described to us by Dr Campbell:

> Two days ago I received a letter from my own primary care trust saying that as a PCT we were quite high in our use of weight-loss medication, and we were to reconsider our practice policies. I cannot recall, in 15 years in general practice, receiving a letter questioning our prescribing of heart disease medication or diabetic medication; and this really typifies the prevailing attitude at the moment.[366]

372. **We were dismayed to hear that a specialist GP who devoted much of his time to trying to tackle obesity in his local population was being put under pressure from his local PCT to reduce his prescribing of drugs to tackle obesity, despite these drugs having received approval from NICE, with the corresponding obligation on PCTs to provide funding for them. We were told by the same doctor that in 15 years of practice he had never received communications questioning his prescribing rates for drugs to treat heart disease or diabetes, two illnesses frequently caused by obesity. This provides a telling exposé of current attitudes towards obesity, whereby it is regarded by NHS decision-makers as a lifestyle problem for which treatment is an optional extra. We recommend that the Government takes urgent steps to tackle this subtle deprioritisation of obesity wherever it occurs in the NHS.**

373. A more drastic option for treating obesity is through surgery. Obesity surgery, also described as bariatric surgery, can be either 'malabsorptive' or 'restrictive'. Malabsorptive surgery works by shortening the length of the digestive tract (gut) so that the amount of food absorbed by the body is reduced. This type of surgery involves creating a bypass by joining one part of the intestine to another. Restrictive surgery limits the size of the stomach so the person feels full after eating a small amount of food. This type of surgery can involve 'stapling' parts of the stomach together or fitting a tight band to make a small pouch for food to enter.[367] Currently, four types of obesity surgery are available: vertical banded gastroplasty, the Lap-Band system, Roux-en Y gastric bypass, or biliopancreatic diversion with a duodenal switch.

365 Ev 2

366 Q1036

367 Nice Technology Appraisal Guidance – No 46, Obesity Surgery, p 3, 19, July 2002

374. NICE have also given their approval for obesity surgery to be funded for NHS patients. Having reviewed 19 clinical trials and other evidence, NICE concluded that:

> surgery for people with morbid obesity is associated with significant weight loss that is maintained for at least 8 years, whereas there is little sustained weight loss with conventional treatment in this group of patients. Surgery is also associated with improved quality of life and reduced co-morbidities. There are significant risks attached to surgery, although these are thought to be outweighed by the benefits.[368]

However, Professor John Baxter, a consultant bariatric surgeon, told us that despite this recommendation obesity surgery services in the UK were 'third world' when compared with other developed countries. NICE's guidance suggested that the NHS should aim to build bariatric services up over the next eight years to around 4,000 procedures per year, from the 200–300 procedures performed in the UK at present. Professor Baxter felt this target number to be "manifestly too low".[369]

375. Based on the assumption that in the UK around 0.8% of males and 2% of females are morbidly obese, Professor Baxter argued that there were currently around 228,000 men and 570,000 women potentially suitable for surgery. If this were expanded to include all patients who had a BMI between 35 and 40 who had a co-morbid condition, this would push the target population up to 1.2 million. On top of this, Professor Baxter estimated that a further 5,000–8,000 patients would become morbidly obese each year. Even if only 5% of suitable patients opted for surgery, in his view a very conservative estimate, this would mean a current "backlog" of around 60,000 patients needing surgery immediately. Professor Baxter told us that the Swedish health service worked on the assumption that to maintain a "steady state", 500–1,000 procedures are needed per year per 500,000 population. Extrapolating this using UK data, around 25,000 procedures would be needed per year in this country, over six times the number recommended by NICE.[370]

376. Dr Finer supported Professor Baxter's view about the problems with obesity surgery:

> Obesity surgery remains virtually unfunded and unavailable to most eligible patients through the failure of district Health Authorities and now Primary Care Trusts to implement NICE guidance.[371]

377. Professor Baxter described provision of bariatric surgery as a "postcode service" and warned that Strategic Health Authorities were now "starting to panic about how to provide this service."[372] He told us that waiting lists were very long in all centres. For his service, in Swansea, the waiting list was one year for an outpatients appointment, followed by three years' wait for surgery, giving a total wait of four years. Another impediment to access was that many suitable patients were not being referred simply because their GPs were ignorant about bariatric surgery. The huge mismatch between capacity and need was shown by

368 Ibid

369 Ev 332

370 Ibid

371 Ev 329

372 Q1058

Professor Baxter's estimate that at least 300 obesity surgeons were needed, compared with the 13 or 14 currently practising.

378. In the United States, we met with two bariatric surgeons who explained that bariatric surgery was a rapidly increasing speciality there. Last year there were 103,000 bariatric operations performed in the US and this figure is projected to rise to 126,000 this year. While up until two years ago, these operations were only carried out in large specialist university hospitals, now almost every private hospital, both large and small, performs the operations.

379. **Bariatric surgery is in no way a panacea for the current obesity epidemic. Rather it is a high-risk, invasive surgical procedure that represents a last line of defence for people with life-threatening morbid obesity. However as the number of people suffering from morbid obesity in England looks set to increase, it is an option that needs to be made available to all those who need it, and it is unacceptable that in some parts of the UK patients with a life-threatening condition are having to wait as long as four years for bariatric surgery. We hope that the measures we have recommended to improve provision of specialist obesity services in both primary and secondary care will help to address the problem that many patients are not referred for bariatric surgery simply because their local doctors are not aware that it is an option. However, the NHS needs also to ensure that adequate service capacity is in place fully to meet need, which is patently not the case at present. The Government must devote protected resources to ensuring that bariatric surgery is available to all those who need it, and should issue guidelines for the strategic development of services across the country, to eliminate the current postcode provision of obesity surgery.**

380. As well as medical and surgical approaches, it is vital that the psychological and behavioural aspects of obesity are addressed. As TOAST pointed out in their written evidence, there are a multitude of reasons why people may overeat, many of them linked to underlying psychological factors:

We have asked a variety of groups why they think obese people overeat. The following list is typical of the answers given:

Boredom	Guilt
Anger	Shame
Stress	Because it's there
Loneliness	Pressure from other people
Happiness	Going to start a diet tomorrow
Revenge	Frustration
Depression	It's Sunday
Addiction	Pleasure
Habit	Unloved
Not appreciated	Unfulfilled
Tired	Unsatisfied
Unhappy	To celebrate
Comfort	Holidays[373]

381. TOAST argued that amongst some groups, obesity was comparable to addictive habits such as smoking or alcohol dependence:

> For many types of obese [people] there is a strong link to the problems of those with a drink problem; many talk of sometimes feeling out of control around food … All the alcohol treatment programmes we know of use some form of counselling within their treatment profile. They recognise that the alcohol is often used as a coping mechanism, to drown sorrows, for swallowing anger, blotting out the pain, to be part of the crowd. Many overeaters will recognise these behaviours and reasons for over consuming. Alcohol treatment programmes help people to recognise why they have been over consuming and to find other coping mechanisms, helping clients build belief in them.[374]

382. TOAST and the Royal College of Psychiatrists both argued strongly that multidisciplinary teams to treat obesity must involve a range of professionals properly equipped to address the psychological and behavioural aspects of obesity, including counsellors, psychiatrists, psychotherapists, psychologists and family therapists.[375] **We feel it is vital that advances in medical and surgical treatment of obesity should be supported by equivalent development of services to address the psychological and**

373 Ev 372

374 Ev 372

375 Appendix 40

behavioural aspects of obesity. All those receiving treatment for obesity, whether in a primary or in secondary care setting, should have access to psychological support provided by an appropriate professional, whether this is a psychiatrist, psychologist, psychotherapist, counsellor, or family therapist.

Prioritisation within the NHS

383. While we agree that the obesity epidemic has, in contrast to other public health concerns which may come to prominence very rapidly, manifested itself gradually and insidiously over a number of years, we were a little surprised to hear the Public Health Minister, Melanie Johnson, argue that it had "caught us all slightly unawares."[376] While it is clear that the Government and the NHS are at present unprepared to deal with this problem on the scale at which it now presents itself, obesity has been recognised as a serious threat to the nation's public health by experts and governments alike for several decades. In 1976, nearly 30 years ago, a report by a joint Department of Health and Social Security and Medical Research Council group highlighted the problem in unequivocal terms:

> We are unanimous in our belief that obesity is a hazard to health and a detriment to well being. It is common enough to constitute one of the most important medical and public health problems of our time, whether we judge importance by shorter expectation of life, increased morbidity, or cost to the community in terms of both money and anxiety.[377]

384. Twelve years ago, the 1992 White Paper *The Health of the Nation* identified targets for obesity reduction. These targets were not met, and obesity increased rather than decreased during this period. However, there were no obesity targets in the 1999 public health White Paper *Saving Lives*, an omission regarded by TOAST as deplorable: "With the obesity epidemic raging, obesity had been dropped, with no strategy being pursued to reduce or limit it."[378] When questioned about why this had happened, Department of Health officials responded that the issue of targets was a question for Ministers. In its memorandum, the Department argued that service-based targets within existing NSFs were sufficient:

> The Priorities and Planning Framework for 2003–06 includes targets for reducing CHD. One of these targets requires practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking. This also covers the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30. In order to tackle health inequalities, the Priorities and Planning Framework also sets a target to contribute to a national reduction in death rates from CHD focusing on the 20% of areas with the highest rates of CHD, and this should encourage action on obesity in disadvantaged areas. The Priorities and Planning Framework has also set a target to increase breastfeeding initiation rates by 2 percentage points each year, particularly among disadvantaged groups.

376 Q1301

377 Cited in Appendix 18 (Royal College of General Practitioners)

378 Ev 369

> Standard One of the NSF for CHD relates to the reduction of coronary risk factors in the population and requires that all NHS bodies will have agreed and be contributing to the delivery of a local programme of effective policies on promoting healthy eating, increasing physical activity and reducing overweight and obesity and have quantified data on the programme by April 2002.[379]

385. Speaking to the *Health Service Journal*, Melanie Johnson, the Public Health Minister, expressed her view that the current package of measures to tackle obesity,—which she listed as the school fruit scheme, the Five-a-day fruit and vegetable initiative, and the as yet unpublished Food and Health Action Plan—when taken together "amounted to a strategy" to tackle obesity.[380]

386. However, none of these things has any direct connection to NHS services to prevent and treat obesity. And although the Government has often cited a reluctance within the health service for more targets and central directives, we in fact received a substantial body of evidence from those working within the NHS who argued strongly in support of a national service framework specifically addressing obesity. Significantly, this call has come both from clinicians and from those involved in NHS management. Dr Ian Campbell, a GP, told us that:

> The impact of a national service framework should not be underestimated within the world of general practice. The National Institute for Clinical Excellence has made many pronouncements on weight management and the use of drugs for surgery, but they are only accepted at a distance by health authorities and not always acted upon; whereas national service frameworks are accepted as being directives that must be done, by which primary care services are judged; so it would have a huge impact on the service that followed.[381]

387. Sally Hayes, the CHD Lead at Leeds North West PCT supported this view, stating that an NSF in obesity "would help greatly" as "the setting of standards and targets does wake us up, as organisations".[382] She described her current means of securing one-off funding for obesity as "a mad scramble to try and bid for this and that", and told us that funding uncertainties prevented her project from being developed further, leading to de-motivation amongst staff involved in tackling obesity.[383]

388. According to the Institute of Human Nutrition at the University of Southampton, a key problem with the UK health system in relation to obesity was that there was "a notable absence of well-structured and validated care pathways" and that furthermore, "there is no formal budgetary responsibility at any level of care—community, primary, secondary or tertiary—for the identification of the overweight and the support and management of those identified as being at special risk."[384]

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379 Ev 15-16

380 *Health Service Journal*, 6 November 2003, pp 26-27

381 Q1041

382 Q1075

383 Q1084

384 Appendix 32

389. Although the Department argued that the references to obesity within the NSFs for CHD and diabetes were sufficient to address obesity, we were told by the Counterweight Project that, ironically, those NSFs were in fact drawing resources *away* from the prevention and treatment of obesity, despite the indisputable link between obesity and both CHD and diabetes:

> The main barriers to continued provision of a structured approach to obesity management have been competing priorities and a lack of dedicated nurse time. Many practices however claim to be prioritising nurse and GP time to meet the national service frameworks for conditions such as diabetes and coronary heart disease. Ironically, many of these competing disease areas can be directly improved by obesity management.[385]

390. Dr Nick Finer, a consultant obesity physician, argued that the references to obesity within two NSFs were scant and ineffectual:

> Although there are odd little lines in the existing NSF to cardiology and diabetes, the fact that they are right down in the sub-sub-sections, means that to all intents and purposes they are ignored.[386]

391. Sally Hayes supported this view:

> Obesity is not specified enough within those standards and milestones. There are other things based on medication, on lifestyle. It is not specific enough really, and the targets are not specific enough.[387]

392. Dr Ian Campbell, in his capacity as Chairman of the National Obesity Forum, was one of many to recommend the appointment of a 'Fat Czar' to develop a central government strategy to tackle obesity on all fronts, in addition to the development of an Obesity National Service Framework and obesity targets for the NHS.

393. **The evidence we received during the course of this inquiry has convinced us that despite its overwhelming importance, obesity remains a low priority for the majority of service commissioners and providers in the NHS. The National Health Service has a responsibility both to take strategic action to prevent obesity, as part of its public health remit, and to provide adequate treatment for those already suffering from overweight or obesity, as it would for those suffering from any other medical condition. It appears to us to be failing in both of these areas, and this needs to change as a matter of urgency.**

394. **We are fully aware that obesity is mentioned in existing NSFs, but we believe that these scant mentions are woefully inadequate to provide a strategic framework through which to tackle what has been described as 'the biggest public health threat of the twenty-first century'. We also understand that a public health White Paper will be published in the summer, but again we fear that the extent and seriousness of the**

385 Ev 346

386 Q1040

387 Q1075

obesity problem will be lost by including obesity only as part of a wider umbrella of general public health initiatives.

395. **We note the Government's reservations about committing to further National Service Frameworks, which they voiced in response to our report on S*exual Health*. However, the current structure of the National Service Framework programme places too great an emphasis on tackling discrete disease areas, focusing on downstream consequences at the expense of the upstream contributors to these diseases, including obesity. Indeed, we heard compelling evidence that many general practices are unable to devote time to tackling obesity because of their obligation to meet targets in the Coronary Heart Disease and Diabetes NSFs, even though, ironically, many of these 'competing' disease areas can be directly improved by tackling obesity. And while it is clear that general public health problems, such as smoking, can be addressed within disease-based NSFs, the lack of obesity targets has led to this area being systematically neglected.**

396. **It is essential that, as part of the Government's wider strategy to tackle obesity, a dedicated framework document is produced to emphasise to a largely sceptical NHS the full scale and seriousness of this problem. The complexity of the challenge facing the NHS in this area, including the need to develop services and care pathways across all tiers of service delivery in a rapidly changing area of medicine, as well as to take the lead on prevention and health promotion, makes a detailed strategic framework vital. This document should build on existing work in this area, drawing together and emphasising the obesity measures already set out in the National Service Frameworks, and linking in with the ongoing work of NICE. Crucially, it must re-introduce realistic but stretching targets for reducing the prevalence of obesity and overweight over the next ten years, underpinned by more detailed, service-based targets, in particular bringing waiting times for specialist medical and surgical obesity services in line with all other NHS specialties. PCTs should be stringently performance-managed on their delivery of these targets.**

4 Conclusion

397. Often the purpose of a select committee inquiry goes beyond the simple 'tick box' approach of making recommendations to Government and seeing how many are accepted. We believe that the very fact of our holding this inquiry has contributed (alongside many other important reports and studies) to the huge publicity that the subject of obesity has prompted over the last year or two, and has helped to raise its profile. *The Daily Telegraph* offered 177 articles on obesity in the year leading up to our inquiry and 337 in the year of our inquiry.

398. One of our witnesses argued that it might be helpful if more stigma attached to obesity so that people made more effort to lose excess weight.[388] We totally disagree with this suggestion. Nevertheless, we have observed an odd tension in society. The world of popular culture, teenage magazines, film, music and sport is usually dominated by fit and slim people. It is generally accepted that these are role models and that people aspire to emulate them. Yet the average person is remorselessly getting heavier and moving further and further away from the ideal. It is as if the pressure to conform to the stereotype, and failing, is pushing people in the opposite direction.

399. We have posited a wide range of measures in our report which attempt to address the issue of obesity. As many witnesses who appeared before us acknowledged, no single measure is likely to reverse the tide of obesity; a wide range of different measures is more likely to have an impact.

400. The rapid rise in obesity is now leading to a proliferation of meetings, conferences and pronouncements on this subject. This is in part extremely welcome in that it raises the awareness of the public, health professionals and policy makers in respect of a vitally important subject. However there is a danger that this could lead to policy overload, as different emphases are given—now on exercise, now on diet. There is a danger that this issue is characterised only within a polemical debate, stressing only the role of a 'devious food industry' on the one hand or the evils of the motor car or gameboy on the other. The evidence we heard suggests both 'energy in' and 'energy out' must be addressed, and indeed, part of the policy confusion is that there is inadequate liaison of policy response between the two 'sectors' of the obesity business. This can easily be exploited by vested interests resistant to change.

401. Many of the measures we recommend relating to physical activity would take years to implement, notably our call for a fundamental cultural change in urban planning to facilitate active travel and active workplaces. It would take even longer to measure the impact of these measures. Nevertheless, we believe it is vital that Government takes seriously its responsibilities to help people become more active.

402. We have commended the commitment and funding now being devoted to organised sport and physical activity in schools. Many of our other proposals would involve

388 Q195 (Professor Julian Peto)

substantial public expenditure, but the dire threat to public finances as well as public health if the obesity epidemic progresses unchecked persuades us that this expenditure is justifiable.

403. **It would be very difficult to disaggregate the possible impact of any of the recommendations we make. We have argued for a coherent package of measures, addressing both sides of the energy equation. We believe they would have more chance of being effective if implemented in full rather than in a piecemeal fashion. However, it is clearly important that some steps are taken to monitor the effectiveness, and the cost-effectiveness of what we propose, in line with the recommendations of the Wanless report on public health. The National Audit Office undertook an influential and ground-breaking report on obesity in 2001. We know that they have maintained an interest in the subject thereafter. So we would like the National Audit Office to conduct further work on the value for money implications of measures taken to combat obesity, since this will be one of the greatest pressures on NHS resources over the coming decades. In calling for this, we also note the point made in the Scrutiny Unit analysis annexed to our report that there is a "severe lack" of official estimates of the costs of diseases relating to obesity. We recommend that the Department undertakes urgent work to establish better estimates of the cost of treating diseases to allow it to manage its resources more effectively.**

404. We believe it is important to offer some perspective on the likely effectiveness of some of the short-term measures we propose in relation to food. One tool for doing this is provided by a substantial piece of research conducted by the investment bank J P Morgan. In a report published in April 2003, the bank investigated the possible impact of the growth of obesity on the food industry.[389] They looked from the perspective of the investor at the possible risks to the volumes of the food industry of greater regulation. Their findings are summarised in the table below:

389 J P Morgan, European Equity Research, *Food Manufacturing: The Big Issue*, pp. 15-21

Table 7: J P Morgan analysis of the impact of regulation on the food industry

Possible action	*Likely impact on the food industry*
Total ban on advertising of food and beverages to children on TV	"We think volumes would suffer. This is because not only are children significant consumers of the segment themselves, through 'pester power' they also drive broader retailing of the category … manufacturers would be faced with the double challenge of shifting the portfolio to healthier products while also finding alternative and innovative ways of selling these to children."
Labels having to have better nutritional information	"The US experience proves that labels containing more information about nutrition do not necessarily encourage people to adopt lower-calorie diets or reduce consumption." "We feel that nutritional labels on European food products may not change consumption patterns."
Targeting of super-size products	"These products carry a higher margin than regular products … were these products to become the target of regulators we believe it would have negative implications for volume growth."
Provision of warning labels for high-energy bars containing more than 500 calories eg Cadbury's Boost	"We believe warning labels may eventually be imposed with a negative effect for the category."
Ban/Tax on Unhealthy Products	"Moderate taxes may not necessarily lead to a decline in obesity rate but will probably help government to finance the costs of informing consumers and treating patients."

405. This analysis is restricted to the impact of possible regulation of the food industry, particularly that targeting so-called junk food manufacturers. It is interesting to note that labelling, which relies on giving consumers more of an informed choice, is seen as likely to have relatively little effect on volumes. Conversely, more draconian measures aimed at reducing the choices available, are seen as more likely to be effective.

406. This raises a question very much at the heart of the debate, and one that we explored throughout our inquiry: how much is obesity the responsibility of the individual making life-style choices; and how much is it the responsibility of Government? This is not simply a philosophical question. It has political ramifications. One reason it is very difficult for governments to intervene is that they risk criticism for operating a 'nanny-state', interfering in the lives of their citizens.

407. We fully accept that there is a degree to which obesity is the personal responsibility of individuals. This is clearly not so plausibly the case for children, who are usually deemed less able to make informed choices. Even here, however, we concede that parents do have a responsibility to try to feed their children healthily, though we acknowledge that, often, unhealthy food is cheaper than healthy options.

408. Whatever stance governments favour politically or philosophically they will inevitably have to deal with the consequences of the epidemic of obesity. If the very existence of the NHS in its present form is threatened by costs spiralling totally out of control it is hard to see that the Government will not, ultimately, be forced to intervene.

409. **Overall in our report we have looked for positive solutions. We have noted the example of Finland, where the force for change came from a grass-roots consumer response which took Government with it, rather than vice versa. We have at several junctures recommended voluntary agreements rather than regulation. We have chosen to accept the word of many representatives of the food industry that they wish to be part of the solution as well as part of the problem. Our belief is that this is a line worth pursuing, not only because it is politically far easier, but also because it could achieve results more quickly than a protracted battle to implement regulation.**

410. **Other pressures will be brought to bear on the food industry. Consumers may start to demand healthier products once unhealthy ones are properly labelled. Litigation—which is already happening in the USA—may alter the products available and customers' perception of those products. The greatly increased media attention to the problem of obesity may ripple through society and produce a change in behaviour.**

411. **This is an optimistic way of looking at the future. However, the recent past trends in the growth of obesity and overweight across the population must temper such optimism. Our concluding thought is that the Government must be prepared to act and intervene more forcefully and more directly if voluntary agreements fail. We recommend that the Government should allow three years to establish those areas where voluntary regulation and co-operation between the food industry and Government have worked and those where they have failed. It should then either extend the voluntary controls or introduce direct regulation.**

Conclusions and recommendations

1. The Clerk's Department Scrutiny Unit has recalculated the total estimated cost of obesity is £3.3–3.7 billion. This is £0.7–1.1 billion (27–42%) more than the NAO estimate for 1998. The difference between the two figures occurs for a number of reasons including higher NHS and drug costs, more accurate data that have been produced recently, the inclusion of more co-morbidities and the increased prevalence of obesity. This figure should still be regarded as an under-estimate. We note that these analyses are for the 20% of the adult population who are already obese. If in crude terms the costs of being overweight are on average only half of those of being obese then, with more than twice as many overweight as obese men and women, these costs would double. This would yield an overall cost estimate for overweight and obesity of £6.6–7.4 billion per year. (Paragraph 66)

2. Given the profound significance of overweight and obesity to the population we believe it is essential that the Government has access to accurate data on the actual calories the population is consuming, including figures for confectionery, soft drinks, alcohol and meals taken outside of the home. Although we acknowledge the difficulties of obtaining accurate data, given the limitations of any self-reported survey, the current information is very weak and clearly underestimates actual calorie consumption. We recommend that work is urgently commissioned to establish a Food Survey that accurately reflects the total calorie intake of the population to supersede the flawed and partial analysis currently available. The Food Standards Agency and Scientific Advisory Committee on Nutrition should advise on this. (Paragraph 72)

3. The relationship between alcohol consumption and obesity is too little understood. We recommend that the Department of Health commissions research into the correlation between trends in alcohol consumption and trends in obesity. (Paragraph 87)

4. We were appalled that a £710,000 campaign, launched by one of Britain's largest snack manufacturers, deliberately deployed a tactic which explicitly sought to undermine parental control over children's nutrition by exploiting children's natural tendency to attempt to influence their parents. The fact that this campaign was approved by the Advertising Standards Authority does not exonerate it, but merely demonstrates the ineffectiveness of current ASA standards and procedures. (Paragraph 111)

5. The causes of obesity are diverse, complex, and, in the main, underpinned by what are now entrenched societal norms. They are problems for which, as our expert witnesses have emphasised, no one simple solution exists. However, to fail to address this problem would be to condemn future generations, for the first time in over a century, to shorter life expectancies than their parents. A recent report by the Royal College of Physicians, Royal College of Paediatrics and Child Health, and the Faculty of Public Health emphasised the need for solutions to be "long term and sustainable, recognising that behaviour change is complex, difficult and takes time." We believe that an integrated and wide-ranging programme of solutions must be adopted as a

matter of urgency, and that the Government must show itself prepared to invest in the health of future generations by supporting measures which do not promise overnight results, but which constitute a consistent, effective and defined strategy. (Paragraph 153)

6. While the NHS is clearly central to tackling obesity through providing specialist health promotion and treatment for people who are already obese, we believe that the most important and dramatic changes will have to take place outside the doctor's surgery, in the wider environment in which people live their lives. And while we recognise that individuals have a key role to play in determining their own health and lifestyles, as the main factors contributing to the rapid rises in obesity seen in recent years are societal, it is critical that obesity is tackled first and foremost at a societal rather than an individual level. (Paragraph 154)

7. We feel strongly that the problem of obesity needs to be recognised and tackled at the highest levels across government. We therefore recommend that a specific Cabinet public health committee is appointed, chaired by the Secretary of State for Health, and that one of its first tasks is to oversee the development of Public Service Agreement (PSA) targets relating to public health in general and obesity in particular, across all relevant government departments. (Paragraph 159)

8. We recommend that the Government should consider either expanding the role of an existing body or bodies, such as the Food Standards Agency or Central Council of Physical Recreation (or linking these), or consider the creation of a new Council of Nutrition and Physical Activity to improve co-ordination and inject independent thinking into strategy. (Paragraph 160)

9. We strongly endorse the Wanless Report's recommendation that the Government must assign clear responsibility for the health educational role, previously played by the Health Education Authority, a fact made clear in correspondence from the Department to the Committee. (Paragraph 169)

10. We were very surprised that despite its occupying 'joint top priority' on the Government's public health agenda, there have been no health education campaigns aimed at tackling obesity. Although we acknowledge its benefits, we do not accept the Government's view that the Five-a-day fruit and vegetable promotion campaign is either designed for, or capable of, addressing the nutritional aspects of obesity. In recent years the Government has funded health education campaigns around, amongst other things, smoking, teenage pregnancy and sexually transmitted infections. The order in which other public health issues have been addressed, and the exclusion to date of obesity from this list, make the Government's actions in this area appear haphazard rather than strategic. (Paragraph 170)

11. If the Government intends seriously to address obesity through health promotion, it must adopt a health education campaign dedicated exclusively to tackling obesity, which should follow the model used in the recent anti-smoking campaign, plainly spelling out the health risks associated with being overweight or obese, and also highlighting those nutritional and lifestyle patterns which are most conducive to weight gain. It should specifically identify 'high risk' foods and drinks, and should

also emphasise the fact that consuming alcoholic drinks, like any other high-calorie food or drink, can also be conducive to unhealthy weight gain. At the same time, it should highlight the importance of physical activity both in preventing obesity and reducing weight levels. Part of the campaign should emphasise the crucial links between obesity and diabetes, and between obesity and cancer (which we have heard is barely known by the public as a whole). We recommend that such a health promotion campaign should be launched as soon as possible, with the Food Standards Agency advising on the nutritional content of such promotion, and the Activity Co-ordination Team, if this remains operational, or alternatively Sport England through its links with Move4Health advising on the physical activity dimension. (Paragraph 171)

12. Understanding the importance of healthy eating is meaningless without the skills to put these messages into practice. The huge demand for initiatives such as the Focus on Food Cooking Bus is a testimony to the extremely limited opportunities for cooking and food training within schools, and also to the desire of both pupils and teachers to have access to this type of training. While we fully support these initiatives and acknowledge the good work they are doing to bring this training back within reach of school pupils, we feel that learning about how to choose and prepare healthy meals should be an integral part of every young person's education, not an optional extra delivered only periodically. This is currently not the case. We recommend that the Government takes steps to reformulate the Food Technology curriculum, so that children of all ages receive practical training in how to choose and prepare healthy food which they can put into practice in their daily lives. As well as practical cookery lessons and classroom lessons about nutrition, children should also be taught how to understand food labelling and how to distinguish food advertising and marketing from objective fact; they could put their knowledge to the test in visits to a local supermarket. Healthy Schools initiatives have demonstrated the additional value of engaging children in projects to grow their own fruit and vegetables, fostering an understanding of where foods come from as well as reinforcing their motivation to eat more healthily. This should also form part of the food curriculum in schools. In order to achieve this, steps will need to be taken to strengthen teacher training in these areas. (Paragraph 174)

13. We recommend that delivery of the Food Technology curriculum should be rigorously inspected by Ofsted. (Paragraph 175)

14. Health promotion campaigns, as the recent anti-smoking advertising campaign has demonstrated, can play a successful role in raising awareness of the risks associated with particular behaviours, and to this end we have recommended that a health education campaign targeting obesity is launched as soon as possible. However, our evidence suggests that obesity has increased rapidly despite the fact that the benefits of a healthy diet have been well known for over 20 years. While we accept that individuals have the right and the responsibility to make choices about their own health and lifestyle, and we accept the importance of health education in enabling them to do so, we believe that to tackle obesity successfully education must be supported by a wider range of measures designed to remove the key barriers to choosing a healthy diet. We therefore recommend that the Government should concentrate its efforts not solely on informing choice, but also on addressing

environmental factors in order to, in its own words, make healthy choices easier to make. (Paragraph 181)

15. While we would clearly support an expansion in the promotion of healthy foods to redress the balance which currently lies entirely in favour of unhealthy foods, this alone seems to be an idealistic and ill thought-through notion, one which we are surprised that the Secretary of State for Culture, Media and Sport was prepared to espouse. (Paragraph 185)

16. Given the scale of the public health hazard the country is confronted by, it would seem appropriate to employ a precautionary approach where evidence is contradictory. As we have said previously, we are committed to long-term solutions to the problem of obesity. The Hastings Review offered stark evidence of the extent to which advertisers of less healthy foods were saturating broadcasting slots targeting children, who are often watching without any adult present. While we would not want to go so far as to call for an outright ban of all advertising of unhealthy food, given the clear evidence we have uncovered of the cynical exploitation of pester power we would very much welcome it if the industry as a whole acted in advance of any possible statutory control, and voluntarily withdrew such advertising. There is clear evidence that the majority of parents do not favour such advertisements during children's television. (Paragraph 192)

17. In one crucial sense, however, we share a concern about the effectiveness of banning or controlling television advertising: as noted above it is only a small part of the enormous food marketing effort that is aimed at children. If television advertising were to be banned, the marketing effort would simply be displaced to other areas—money previously spent on television advertising would, for example, be diverted to point of sale or internet promotion. (Paragraph 193)

18. We gather that the Secretary of State for Culture, Media and Sport is in discussion with OFCOM over the marketing of less healthy foods. We would like her to review the whole marketing function. In particular, we would like her to address some of the issues the Irish Broadcasting authorities are looking at, namely the impact of product endorsement of less healthy food by sports stars, and other celebrities; guidance on how these products can actually fit into a healthy diet, perhaps linking into nutritional information; and their impact on the energy equation in terms of the activity needed to displace the calories they add. Assuming the food and advertising industry is genuine in its desire to be part of the solution, a starting point for this would be for companies to agree clear public health targets. (Paragraph 194)

19. As we noted earlier, we were disturbed at the ineffectiveness of the Advertising Standards Authority, which is an industry self-regulation system. We recommend that OFCOM be asked to review the role of the ASA with a view to improving its effectiveness. This is not the first occasion on which the Health Committee has found the performance of the ASA to be disappointing. (Paragraph 195)

20. We feel that the school environment can have a strong influence over children's developing nutritional habits, and that the Government must not neglect this crucial opportunity to promote healthy eating to children and help them develop sound

lifelong habits. Healthy eating messages learnt through the national curriculum and Government healthy eating initiatives such as the schools fruit campaign will be contradicted and undermined if, within that same school environment, children are exposed to sponsorship messages from unhealthy food manufacturers, and given access to vending machines selling unhealthy products. There is evidence that parents are keen to see unhealthy influences removed from schools, with recent research finding that as many as 70% of parents were in favour of banning vending machines in schools. Recent research by the FSA also indicates that children are willing to purchase healthier drinks from vending machines when they are given the option. Given the worryingly steep rise in levels of childhood obesity, we feel that parents, teachers and school governors must all be fully engaged in tackling it, and that obesity should command a high priority on school board agendas. (Paragraph 199)

21. We therefore recommend that all schools should be required to develop school nutrition policies, in conjunction with parents and children, with the particular aim of combating obesity, but also of improving nutrition more generally. In conjunction with this, the Government should issue guidance to all schools strongly recommending that that they do not accept sponsorship from manufacturers associated with unhealthy foods or install vending machines selling unhealthy foods. If Government insists that this is a matter for local determination, we believe that governors should permit such practices only if these are shown to be supported by a clear majority of parents. The guidance should also give firm support for the replacement of existing vending machines with ones selling healthy foods and drinks. (Paragraph 200)

22. Nutritional labelling is intended to help consumers make sound nutritional decisions when buying food, but the current state of such labelling seems to be having, if anything, the opposite effect. We have repeatedly heard the argument, both from the food industry and from the Government, that there are no such things as good or bad foods, only good or bad diets. However, both the food industry and the Government have embraced the concept of labelling certain foods as 'healthy' with great enthusiasm, inviting the obvious conclusion that other foods must be, by definition, less healthy. (Paragraph 214)

23. The Government must accept the clear fact that some foods, which are extremely energy-dense, should only be eaten in moderation by most people, and we therefore recommend that it introduces legislation to effect a 'traffic light' system for labelling foods, either 'red—high', 'amber—medium' or 'green—low' according to criteria devised by the Food Standards Agency, which should be based on energy density. This would apply to all foods. Not only will such a system make it far easier for consumers to make easy choices, but it will also act as an incentive for the food industry to re-examine the content of their foods, to see if, for example, they could reduce fat or sugar to move their product from the 'high' category into the 'medium' category. (Paragraph 216)

24. Bearing in mind Derek Wanless's suggestion that greater effort needs to be made to measure the effectiveness of different interventions, we believe that this recommendation would lend itself well to objective assessment. If the scheme we

propose is accepted, it would be relatively simple to measure the impact on the range of relatively healthy and unhealthy foods offered by supermarkets, and any shift in the patterns of consumption from relatively unhealthy to relatively healthy products. (Paragraph 217)

25. We note the Government has made efforts to date to reduce salt levels in foods, but we feel that urgent attention should also be given towards tackling obesity. We recommend that, rather than targeting sugar and fat separately, the Government should focus on reducing the overall energy density of foods, and should work with the Food Standards Agency to develop stringent targets for reformulation of foods to reduce energy density within a short time frame. While we expect that reformulation could be achieved through voluntary arrangements with industry, and while we believe that the introduction of legislation in respect of labelling will encourage industry to make the entire product range healthier, the Government must be prepared, in the last resort, to underpin this with tougher measures in the near future if voluntary measures fail. (Paragraph 222)

26. The notion of taxing unhealthy foods is fraught with ideological and economic complexities, and at this stage we have not seen evidence that taking such a significant and difficult step would necessarily have the hoped-for effect of reducing obesity. We recommend, instead, that the Government should keep an open mind on this issue, and monitor closely the effect of fat taxes introduced in other countries. We also recommend that the Government should take steps to address the anomalies in the current arrangements for VAT on unhealthy 'treat' foods as it is clearly ludicrous that VAT is levied on ice cream and fizzy drinks but not on Bourbon biscuits or cakes. (Paragraph 228)

27. We hope that as the Government and food industry work together to reduce the energy density of foods, the need for 'healthy' options will be gradually reduced, with standard versions of foods being healthy as a matter of course. However, as this is likely to be a phased process, we recommend that in the short term the Government must work with the food industry to ensure that 'healthy' versions of foods, with reduced calories and fat, are available at an affordable price. (Paragraph 230)

28. As a matter of urgency, the Government must redouble its efforts to reform the Common Agricultural Policy as part of the public health agenda, and the future UK presidency from July 2005 will afford an opportunity for this to be done. Obesity is, after all, a growing problem in almost all EU countries. The issue of agricultural policy presents a perfect opportunity for the Government to demonstrate that it is committed to tackling public health issues in a joined-up way, an opportunity which in our view it has to date entirely neglected. However, as noted above, progress on the CAP will be extremely difficult unless public heath is given much greater emphasis in Europe. We therefore call on the Government to use its influence, and its forthcoming presidency, to encourage the Commission to reconsider the Treaty of Rome and put public health on an equal footing with trade and economics. (Paragraph 237)

29. In the interim, the Government, led by the Treasury should emulate the Swedish Government and produce a Health Audit of the CAP, and build a stronger alliance of

Health Ministries to combat other interests protecting the status quo in public policy. (Paragraph 238)

30. During this inquiry we have heard repeatedly that industry is keen to be 'part of the solution'. If this desire is to be translated into reality, then supermarkets should adopt new pro-active pricing strategies that positively support healthy eating, rather than acquiesce in the view that their duty to their customers goes no further than simply providing the range of foods which they want to buy. As part of their healthy pricing strategies, supermarkets must commit themselves to phasing out price promotions that favour unhealthy foods, and also stop all forms of product placement which give undue emphasis to unhealthy foods, in particular the placement of confectionery and snacks at supermarket checkouts. Alongside this, all sectors of the food industry should collaborate in the phasing out of super-sized food portions. We expect that the food industry will be keen to capitalise on the significant commercial opportunity that introducing these policies will present, and indeed much good work has already been done in this area. Several supermarkets have already committed themselves to banning the placement of confectionery at checkouts, and Kraft and McDonalds have begun to limit the availability of super-size portions. We commend fast-food outlets for offering fruit and salad options, though we request that these should be promoted more effectively than at present. Those companies who do not comply with Government guidance on healthy pricing, including product placement and super-sizing, should be publicly named and shamed. (Paragraph 241)

31. We recommend that the Department for Education and Skills extend the scope of the FSA review of the implementation of nutritional standards, with a view to developing appropriate nutrient based standards for school breakfasts. (Paragraph 248)

32. Furthermore, we recommend that the Department for Education and Skills takes steps to ensure that all children eat a healthy school meal at lunchtime, both through improving the provision of attractive and palatable 'healthy' options, and through restricting the availability of unhealthy foods. The Government should shift from the current 'food-based' standards towards the 'nutrition-based' standards being introduced in Scotland. The quality of school meals should also be taken into account by Ofsted inspections. (Paragraph 249)

33. We commend the wide range of measures and substantial funding being directed by the Government towards physical activity, particularly in schools. While we have reservations about the effectiveness of measures taken to date, we wish to pay tribute to the efforts that have been made in the last two years and to acknowledge the substantial funding that has been provided. (Paragraph 268)

34. We regard it as lamentable that the majority of the nation's youth are still not receiving two hours of sport and physical activity per week. While we very much welcome the DCMS/DfES target to have 75% of school children thus active by 2006 we do not believe that this goes far enough. We have reservations about the quality of much of the activity undertaken, since little work has been done to establish what the two hours involves, and whether it includes, for example, time taken in travelling to

and from facilities. Moreover, even the two hour target puts England below the EU average in terms of physical activity in school, despite the fact that childhood obesity is accelerating more quickly here than elsewhere. (Paragraph 275)

35. We recommend that, given the threat of obesity to the current generation of children and taking account of the proven contribution of physical activity to academic achievement, the aspiration should be for school children to participate in three hours per week of physical activity, as recommended by the European Heart Network. (Paragraph 276)

36. Relentless pressure on the curriculum has served to squeeze out school sport and PE. However, there is ample evidence that being physically active benefits children's academic performance, and many schools in the independent sector offer four or more hours of exercise per week. We know that the Government is monitoring closely the Brent project but that it has been less than forthcoming with supportive funding. We believe that this is a fascinating pilot project and would like to see it rigorously evaluated. Given its potential importance as a model, we also think it would be helpful if the Department's favourable initial appraisal of the scheme were supported by funding. (Paragraph 277)

37. We recommend that the Curriculum Authority should address ways of diversifying organised and recreational activity in schools to embrace areas such as dance or aerobics to broaden the appeal of PE and to counteract the elitism, embarrassment and bullying that the changing room sometimes creates. (Paragraph 278)

38. We do not think it appropriate that the activity of a school in delivering the physical activity agenda should be extrinsic to any evaluation of its overall performance. Physical activity is not—or should not be—a second order consideration. Not only is it crucial to children's health but it also directly benefits academic performance. So we recommend that the Ofsted inspection criteria should be extended to include a school's performance in encouraging and sustaining physical activity. (Paragraph 279)

39. We recommend that the Department for Education and Skills, as part of its wider work to improve self-esteem and self-confidence amongst school children, should ensure that each school, as part of its policy against bullying, remains alert to the particular issue of bullying of children who are overweight or obese. Teachers should receive training in children's diet, physical activity levels, and how to help obese children combat bullying, without further stigmatising them. (Paragraph 280)

40. We believe that providing safe routes to school for walking and cycling, adequate and safe play areas in and out of school is very important in the battle against obesity. (Paragraph 284)

41. The measures proposed by the Environment, Transport and Regional Affairs Committee in its report *Walking in Towns* 2001 strike us as sensible and persuasive and we are sorry so little action has been taken to implement them. (Paragraph 287)

42. Given the profound impact increased levels of activity would have on the nation's health, quite aside from the obvious environmental benefits, it seems to us entirely

unacceptable that successive governments have been so remiss in effectively promoting active travel. (Paragraph 288)

43. We regard the failure of the Department for Transport to produce a National Walking Strategy over a period of almost ten years as scandalous. This very inactivity clearly demonstrates that the priorities of the Department lie elsewhere. We would be extremely disappointed if concerns about political embarrassment had indeed obstructed such an important policy. One way of defusing any political embarrassment would be to incorporate the walking strategy into a wider anti-obesity strategy. (Paragraph 292)

44. We believe it would be helpful if commercial firms issuing pedometers also issued guidance agreed with Sport England and the FSA, on the recommended activity levels per day and on the correlation between steps taken and calories consumed. (Paragraph 297)

45. We welcome the funding the Department of Health has provided to a pilot project on the use of pedometers. We recommend that the Department co-ordinates inter-departmental activity with a view to achieving wide-spread use of pedometers in schools, the workplace and the wider community. (Paragraph 299)

46. It would not be appropriate for us to spell out the individual measures required to achieve the Government's ambitious cycling targets, although we were particularly impressed by the segregation of cyclists from road traffic we witnessed in Odense. If the Government were to achieve its target of trebling cycling in the period 2000–2010 (and there are very few signs that it will) that might achieve more in the fight against obesity than any individual measure we recommend within this report. So we would like the Department of Health to have a strategic input into transport policy and we believe it would be an important symbolic gesture of the move from a sickness to a health service if the Department of Health offered funding to support the Department for Transport's sustainable transport town pilots. (Paragraph 316)

47. There will be profound economic as well as health costs to be paid if the current obesity epidemic continues unchecked. Major planning proposals and transport projects are already subject to environmental impact assessment; we believe that it would be appropriate if a health impact assessment were also a statutory requirement. This would enable health to be integrated into the planning procedure and help bring about the sort of creative, joined-up solution which is required. This may seem a cumbersome and drastic step but we believe that only such strong measures will help reverse the dramatic decline in everyday activity that has occurred in recent decades. (Paragraph 321)

48. We recommend that the Department of Health, in conjunction with the Department for Work and Pensions and the Department of Trade and Industry first organises a major conference to promote awareness of obesity in the work-place and then engages in an ongoing process of consultation to see how measures can be taken to address sedentary behaviour. We recommend that these Departments consult with the Treasury to see what fiscal incentives can be provided to promote active travel. (Paragraph 328)

49. We also recommend that the public sector looks to set an example in finding creative ways of encouraging activity in everyday life, and that this is built into a PSA target for each Department. (Paragraph 329)

50. We welcome the creation of the Activity Co-ordination Team though we regret it took so long for it to begin its work. Anything that co-ordinates Government activity in this complex and challenging field is worthwhile. We await with interest the publication of its first report. We recommend that its reports explicitly link its activity to the Government's specific targets on activity both in schools and in the community. (Paragraph 334)

51. The Department agreed that Strategic Health Authorities (SHAs) should have information about local work on obesity at their fingertips, and we recommend that a survey of action on obesity, both at PCT and SHA level, should be undertaken as part of the ongoing work on the forthcoming White Paper on public health. (Paragraph 337)

52. We feel strongly that Primary Care Trusts should be taking a more active role in preventing obesity, and urge the Government to ensure that PCTs have the capacity, competency and incentive to fulfil their crucial obligation to safeguard the public health of the local communities they serve. We also endorse the recommendation of the Wanless report that the Healthcare Commission should develop a robust mechanism for assessing performance of both PCTs and Strategic Health Authorities with respect to public health. (Paragraph 343)

53. We feel that this country's well developed network of primary care providers, local GPs, provides a unique resource for health promotion and for the identification and management of patients who are overweight or obese. However, managing weight problems sensitively and successfully requires specialist skills, and we are concerned by suggestions that obesity is viewed by many clinicians as a lifestyle issue rather than a serious health problem requiring active management to prevent dire health consequences. We deplore the low priority given to obesity by the new GP contract. We hope that NICE guidance on the prevention, identification, evaluation, treatment and weight maintenance of overweight and obesity, currently expected in Summer 2006, will go some way towards increasing the priority of obesity within general practice, as well as helping primary care practitioners develop and improve the services they provide in this difficult area. The Government should also ensure that within each PCT area there is at least one specialist primary care obesity clinic, probably supported by a range of different health professionals, to which GPs can refer any patients they identify as needing specialist support to address a developing or existing weight problem. (Paragraph 355)

54. We recommend that, in establishing primary care obesity clinics, PCTs should fully explore the possibilities of using less traditional models of service delivery, involving clinicians from across the professional spectrum, from nurses to pharmacists to dieticians. The full range of interventions available to treat obesity includes diet, lifestyle, medical treatment and surgical treatment. (Paragraph 356)

55. We also took some interesting evidence from commercial slimming organisations. We recommend that the NHS examines whether their expertise can be brought to bear in devising strategies to combat obesity holistically. (Paragraph 357)

56. Obesity is a serious medical problem. Although in common with other illnesses, its prevention and some first-line management can be delivered within a primary care setting, patients with more entrenched or complex problems need prompt access to specialist medical care. Childhood obesity is a worrying and increasingly common subset of this illness, and children in particular need specialist care. Yet specialist obesity services seem to be an almost entirely neglected area of the NHS, apparently exempt from Government initiatives to push down waiting times despite their obvious importance in preventing a large range of other debilitating and costly diseases. We therefore recommend that the Government provides funding for the large scale expansion of obesity services in secondary care, underpinned by careful management to ensure that the service provision is matched to need. The Government's maximum waiting time targets must apply to all of these services. (Paragraph 363)

57. We were appalled to learn of the desperate inadequacy of treatment and support services for obese children. Steps must be taken to ensure that obese children and young people have prompt access to specialist treatment wherever they live. (Paragraph 366)

58. We recommend that throughout their time at school, children should have their Body Mass Index measured annually at school, perhaps by the school nurse, a health visitor, or other appropriate health professional. The results should be sent home in confidence to their parents, together with, where appropriate, advice on lifestyle, follow-up, and referral to more specialised services. Where appropriate, BMI measurement could be carried out alongside other health care interventions which are delivered at school, for example inoculation programmes. Care will need to be taken to avoid stigmatising children who are overweight or obese, but given that research indicates that many parents are no longer even able to identify whether their children are overweight or not, this seems to us a vital step in tackling obesity. (Paragraph 369)

59. We were dismayed to hear that a specialist GP who devoted much of his time to trying to tackle obesity in his local population was being put under pressure from his local PCT to reduce his prescribing of drugs to tackle obesity, despite these drugs having received approval from NICE, with the corresponding obligation on PCTs to provide funding for them. We were told by the same doctor that in 15 years of practice he had never received communications questioning his prescribing rates for drugs to treat heart disease or diabetes, two illnesses frequently caused by obesity. This provides a telling exposé of current attitudes towards obesity, whereby it is regarded by NHS decision-makers as a lifestyle problem for which treatment is an optional extra. We recommend that the Government takes urgent steps to tackle this subtle deprioritisation of obesity wherever it occurs in the NHS. (Paragraph 372)

60. Bariatric surgery is in no way a panacea for the current obesity epidemic. Rather it is a high-risk, invasive surgical procedure that represents a last line of defence for

people with life-threatening morbid obesity. However as the number of people suffering from morbid obesity in England looks set to increase, it is an option that needs to be made available to all those who need it, and it is unacceptable that in some parts of the UK patients with a life-threatening condition are having to wait as long as four years for bariatric surgery. We hope that the measures we have recommended to improve provision of specialist obesity services in both primary and secondary care will help to address the problem that many patients are not referred for bariatric surgery simply because their local doctors are not aware that it is an option. However, the NHS needs also to ensure that adequate service capacity is in place fully to meet need, which is patently not the case at present. The Government must devote protected resources to ensuring that bariatric surgery is available to all those who need it, and should issue guidelines for the strategic development of services across the country, to eliminate the current postcode provision of obesity surgery. (Paragraph 379)

61. We feel it is vital that advances in medical and surgical treatment of obesity should be supported by equivalent development of services to address the psychological and behavioural aspects of obesity. All those receiving treatment for obesity, whether in a primary or in secondary care setting, should have access to psychological support provided by an appropriate professional, whether this is a psychiatrist, psychologist, psychotherapist, counsellor, or family therapist. (Paragraph 382)

62. The evidence we received during the course of this inquiry has convinced us that despite its overwhelming importance, obesity remains a low priority for the majority of service commissioners and providers in the NHS. The National Health Service has a responsibility both to take strategic action to prevent obesity, as part of its public health remit, and to provide adequate treatment for those already suffering from overweight or obesity, as it would for those suffering from any other medical condition. It appears to us to be failing in both of these areas, and this needs to change as a matter of urgency. (Paragraph 393)

63. We are fully aware that obesity is mentioned in existing NSFs, but we believe that these scant mentions are woefully inadequate to provide a strategic framework through which to tackle what has been described as 'the biggest public health threat of the twenty-first century'. We also understand that a public health White Paper will be published in the summer, but again we fear that the extent and seriousness of the obesity problem will be lost by including obesity only as part of a wider umbrella of general public health initiatives. (Paragraph 394)

64. We note the Government's reservations about committing to further National Service Frameworks, which they voiced in response to our report on S*exual Health*. However, the current structure of the National Service Framework programme places too great an emphasis on tackling discrete disease areas, focusing on downstream consequences at the expense of the upstream contributors to these diseases, including obesity. Indeed, we heard compelling evidence that many general practices are unable to devote time to tackling obesity because of their obligation to meet targets in the Coronary Heart Disease and Diabetes NSFs, even though, ironically, many of these 'competing' disease areas can be directly improved by tackling obesity. And while it is clear that general public health problems, such as

smoking, can be addressed within disease-based NSFs, the lack of obesity targets has led to this area being systematically neglected. (Paragraph 395)

65. It is essential that, as part of the Government's wider strategy to tackle obesity, a dedicated framework document is produced to emphasise to a largely sceptical NHS the full scale and seriousness of this problem. The complexity of the challenge facing the NHS in this area, including the need to develop services and care pathways across all tiers of service delivery in a rapidly changing area of medicine, as well as to take the lead on prevention and health promotion, makes a detailed strategic framework vital. This document should build on existing work in this area, drawing together and emphasising the obesity measures already set out in the National Service Frameworks, and linking in with the ongoing work of NICE. Crucially, it must re-introduce realistic but stretching targets for reducing the prevalence of obesity and overweight over the next ten years, underpinned by more detailed, service-based targets, in particular bringing waiting times for specialist medical and surgical obesity services in line with all other NHS specialties. PCTs should be stringently performance-managed on their delivery of these targets. (Paragraph 396)

66. It would be very difficult to disaggregate the possible impact of any of the recommendations we make. We have argued for a coherent package of measures, addressing both sides of the energy equation. We believe they would have more chance of being effective if implemented in full rather than in a piecemeal fashion. However, it is clearly important that some steps are taken to monitor the effectiveness, and the cost-effectiveness of what we propose, in line with the recommendations of the Wanless report on public health. The National Audit Office undertook an influential and ground-breaking report on obesity in 2001. We know that they have maintained an interest in the subject thereafter. So we would like the National Audit Office to conduct further work on the value for money implications of measures taken to combat obesity, since this will be one of the greatest pressures on NHS resources over the coming decades. In calling for this, we also note the point made in the Scrutiny Unit analysis annexed to our report that there is a "severe lack" of official estimates of the costs of diseases relating to obesity. We recommend that the Department undertakes urgent work to establish better estimates of the cost of treating diseases to allow it to manage its resources more effectively. (Paragraph 403)

67. Overall in our report we have looked for positive solutions. We have noted the example of Finland, where the force for change came from a grass-roots consumer response which took Government with it, rather than vice versa. We have at several junctures recommended voluntary agreements rather than regulation. We have chosen to accept the word of many representatives of the food industry that they wish to be part of the solution as well as part of the problem. Our belief is that this is a line worth pursuing, not only because it is politically far easier, but also because it could achieve results more quickly than a protracted battle to implement regulation. (Paragraph 409)

68. Other pressures will be brought to bear on the food industry. Consumers may start to demand healthier products once unhealthy ones are properly labelled. Litigation—which is already happening in the USA—may alter the products available and customers' perception of those products. The greatly increased media attention to

the problem of obesity may ripple through society and produce a change in behaviour. (Paragraph 410)

69. This is an optimistic way of looking at the future. However, the recent past trends in the growth of obesity and overweight across the population must temper such optimism. Our concluding thought is that the Government must be prepared to act and intervene more forcefully and more directly if voluntary agreements fail. We recommend that the Government should allow three years to establish those areas where voluntary regulation and co-operation between the food industry and Government have worked and those where they have failed. It should then either extend the voluntary controls or introduce direct regulation. (Paragraph 411)

Annex 1: The economic costs of obesity: A note prepared by the Scrutiny Unit, Clerk's Department, House of Commons

1. This annex sets out to give a broad estimate of the cost of obesity in England. It uses the methodology employed by the NAO in *Tackling Obesity in England*. It updates the data used in that report, from 1998 figures to the latest available, which is 2002 in most cases. It extends the coverage of the calculations to look at a wider range of diseases that are attributable to obesity. It looks at future costs in a very general way. It makes no specific cost estimates, but identifies the driving forces and how increases in costs might differ from increases in the prevalence of obesity.

NAO report

2. *Tackling Obesity in England* estimated that the direct cost of treating obesity and its consequences was £480 million (1.5% of NHS expenditure) and indirect costs (loss of earnings due to sickness and premature mortality) amounted to £2.1 billion. Both figures relate to 1998. A total projected figure of £3.6 billion was given for 2010. On numerous occasions the authors state that they believe various elements to either be conservative estimates or underestimates, due to the exclusion of a number of elements or a lack of data in certain areas:[1]

> We have deliberately produced conservative estimates to raise their credibility as the basis of further discussion of this report in the face of a number of uncertainties.

3. Some of the more expensive areas that were not included (for various reasons) include social care, lipid regulating drugs, appointments with primary care practitioners other than GPs, and the costs of depression and lower back pain attributable to obesity. The report's estimate was a point figure, rather than a range. Presumably this figure would have been at the bottom of any range estimate that would have been given.

4. *Tackling Obesity in England* mentioned that estimates of the direct costs of treating obesity from other countries with similar levels of obesity varied from 2–6% of health spending. If such a range applied to England then the costs would have been between £0.7 and £2.1 billion in 1998. The NAO figure was therefore lower than any of these 'comparable' countries. The table below summarises cost estimates for all countries alongside data on obesity levels. It shows the percentage cost figure for England at joint lowest with France. At the time of the estimates the rate of obesity in France was around one-third of the level in England, of the countries shown only the US had a higher level. The table only gives two recent estimates for the US. Studies from the mid-1980s to the mid 1990s gave a range of 5.5–7.8%.[2]

1 NAO, *Tackling Obesity in* England (2001), para. 2.27; see also appendix 6 paras 17-18, 22, 25, 28 and 33-34

2 *Obesity in Europe The Case for Action*, International Obesity Taskforce

Estimates of the direct costs of obesity

Country	Year of estimate	Proportion of total healthcare expenditure due to obesity	Prevalence of obesity (BMI>30) At time of estimate	Latest
US	1999	8.5%	30.5%	30.5%
US	2000	4.8%	30.5%	30.5%
Netherlands	1981-89	4%	5.0%	10.3%
Canada	1997	2.4%	14.0%	13.9%
Portugal	1996	3.5%	11.5%	14.0%
Australia	1989/90	>2%	10.8%	22.0%
England	1998	1.5%	19.0%	23.5%
France	1992	1.5%	6.5%	9.0%

Sources: *Obesity in Europe The Case for Action, International Obesity Taskforce*
Wolf AM, Colditz GA. Current estimates of the economic cost of obesity in the United States. Obes Res. 1998 Mar; 6(2):97-106
The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity, Office of the Surgeon General
Costs of Obesity, American Obesity Association
OECD Health Data 2003

5. Overall the table shows a wider range of estimates but an inconsistent link between higher obesity and higher costs. If we ignore England then at the extremes more obesity means a higher cost estimate and *vice versa*, but the picture is more mixed for the other countries. Given the very different use of cost estimation methods, definitions of obesity, population structures and systems of healthcare it would be remarkable if there were a simple linear relationship. It is highly likely that the very large range shown is in part due to differing methodologies and is presumably the most likely reason why the figure for England is where it is. It is particularly noticeable that only the US has multiple estimates (six since 1986). These have varied considerably. Having a range of estimates can improve the debate about the economic impacts of obesity.

6. There are even fewer estimates of the indirect costs of obesity from other countries. A study in the US estimated the indirect costs at slightly less than the direct costs ($47.6 billion, compared to $51.2 billion in 1995, uprated to $61 billion and $56 billion in 2000).[3] It is difficult to make any direct comparisons with the estimates for England, but the most striking difference is that indirect costs were smaller in the US estimate, but were over four times greater in the estimate for England.

Direct costs

Treating obesity

7. As mentioned earlier, the same basic methodology employed by the NAO is used for these calculations. The limitations outlined in *Tackling Obesity in England* should therefore be borne in mind when interpreting all the estimates in this Annex. There are some improved data sources that have recently become available, most notably *NHS Reference Costs* which give much more detailed and accurate cost information for different diagnosis/procedure groups.

3 Wolf AM, Colditz GA. "Current estimates of the economic cost of obesity in the United States", *Obesity Research* 1998 Mar; 6(2):97-106; *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*, Office of the Surgeon General

8. *GP consultations* —The unit cost figure for GP consultations used here is from the same source as the NAO figure,[4] but also includes an element for direct care staff. As with the NAO figure there is no direct estimate of the costs of other primary practitioners. There is also no more up to date information on consultations for obesity. The 1991–92 figures are still the most up to date and comprehensive consultation rates.[5] Assuming that the number of consultations has increased in line with the prevalence of obesity[6] then costs would be in the region of £12–15 million. While simply increasing consultation figures by the percentage increase in obesity is a crude method, the alternative is to simply ignore the 50% increase in obesity since 1991–92.

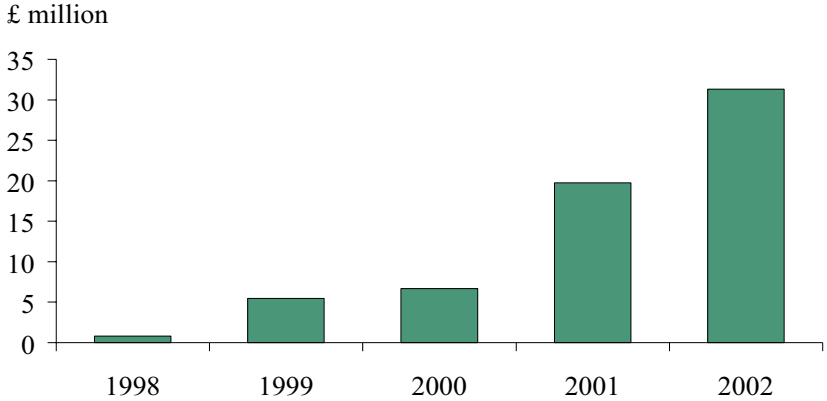
9. *Ordinary admissions*—Using data on admissions for 2002–03[7] and the latest cost figures[8] gives an estimate of around £2 million. The actual number of admissions for obesity fell by almost 25% between 1998 and 2002.

10. *Day cases*—The number of day cases has increased slightly, but they are still very small in number at 360 in 2001–02. The estimated cost is £0.12 million.

11. *Outpatient attendances*—The number of outpatient attendances are uprated in the same way as GP consultations. Combined with a slightly higher unit cost the estimate is £0.5–0.7 million.

12. *Prescriptions*—The total cost for all obesity-related drugs has increased rapidly since 1998 with the licensing of orlistat. The total cost in 2002 was £31.3 million.[9] The chart below illustrates the pace of growth. Over the same period the number of prescriptions for orlistat increased from 18,000 to over 540,000. This may have resulted in a greater increase in GP consultation than that assumed earlier.

Cost of prescriptions for anti-obesity drugs in England



4 *Unit costs of health and social care 2003*, PSSRU, University of Kent at Canterbury

5 Morbidity Statistics from General Practice, fourth national study 1991-1992, MB5 no.3, RCGP/OPCS

6 Health Survey for England, 2002, DH (Department of Health)

7 Hospital Episode Statistics 2002-03, DH

8 NHS Reference Costs 2002, DH

9 Prescription Cost Analysis 2002, DH

13. When combined this gives a total estimated cost for treatment of between £46 million and £49 million. This is around four times the NAO figure, the vast majority of this increase being due to the increase in drug costs. The breakdown of this estimate and that produced by the NAO are given below.

The estimated costs of treating obesity in England: 1998 and 2002

£ millions

	1998	2002
GP consultations	6.8	12-15
Ordinary admissions	1.3	1.9
Day cases	0.1	0.1
Outpatient attendances	0.5	0.5-0.7
Prescriptions	0.8	31.3
Total cost of treating obesity	**9.5**	**45.8-49.0**

14. The real level of uncertainty is somewhat greater than that indicated in the table as the unit costs chosen are necessarily somewhat inexact. However, the most precise information is produced for prescription costs, the largest element, so there is a relatively small amount of uncertainty about this estimate.

Treating the consequences of obesity

15. The box opposite lists diseases and complications that are most often linked to obesity.[10] Those in bold were included and costed by the NAO. A number of the others were explicitly excluded. Just because a particular disease or condition has been linked in publications relating to obesity does not necessarily mean that there is research showing a significantly higher risk. In some cases the evidence is rather weak, mixed or absent. In others the diseases/conditions are far too unspecific to quantify, like 'reproductive problems' or 'surgical problems'. The evidence for these is more anecdotal.

16. Among the diseases not included by the NAO evidence of a statistically significant increased risk was found for post menopausal breast cancer,[11] lower back pain (among women only),[12] hyperlipidaemia[13] and sleep apnoea.[14] Of the remaining diseases/conditions depression has the greatest potential for altering any estimate of the cost of obesity.

17. The methodology for calculating total costs of these diseases is the same as that used for obesity. New estimates of the percentage of cases attributable to obesity were calculated for the additional diseases and updated for the original ones to take account of the increased prevalence of obesity between 1998 and 2002. Some further comments specific to these diseases are given below.

Diseases linked to obesity

Type 2 diabetes
Hypertension
Angina pectoris
Myocardial infarction
Cancers
- **Endometrial**
- **Colon**
- **Rectal**
- **Ovarian**
- **Prostate**
- Breast
- Kidney
- Gallbladder

Osteoarthritis
Gout
Stroke
Gallstones
End stage renal disease
Liver disease
Low back pain
Sleep apnoea
Urinary incontinence
Hyperlipidaemia
Polycystic Ovary Syndrome
Breathing problems
Complications in pregnancy
Complications in surgery
Psychological and social problems
Reproductive disorders

18. The following table shows estimates of the costs of treating the consequences of obesity for 2002 and compares this to the original estimates. Each element, and the total, is given a range to reflect the remaining uncertainty about the precise number of cases attributable to obesity.

10 This list is based on diseases associated with obesity in: Annual Report of the Chief Medical Officer 2002, Department of Health, American Obesity Association, Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults –The Evidence Report, National Institute of Health.

11 van den Brandt PA et al, "Pooled analysis of prospective cohort studies on height, weight and breast cancer risk", *Am J Epidemiol*. 2000 Sep 15; 152(6):514-27

12 Lake JK et al, "Back pain and obesity in the 1958 British birth cohort. Cause or effect?" *J Clin Epimemiol*, 2000 Mar 1;53(3):245-50

13 Brown CD et al, "Body mass index and the prevalence of hypertension and dyslipidaemia", *Obes Res.* 2000 Dec;8(9):605-19

14 Young T et al, "The occurrence of sleep-disordered breathing among middle-aged adults", *N Engl J Med.* 1993 Apr 29;328(17):1230-35

The estimated costs of treating the consequences of obesity in England: 1998 and 2002
£ millions

	1998	2002
GP consultations	45	90-105
Ordinary admissions	121	210-250
Day cases	5	10-15
Outpatient attendances	52	60-90
Prescriptions	247	575-625
Total cost of treating the consequences	**470**	**945-1,075**

19. The largest increase in percentage terms was in the cost of day cases; however at £5–10 million the actual increase was relatively small. The largest increase in cash terms was in the cost of prescriptions at around £225–275 million. The cost of outpatient attendances increased by the smallest proportion. Within individual diseases hypertension was still the most costly with a total of £225–275 million estimated as attributable to obesity. The next most costly was one of the additional co-morbidities added for this exercise—hyperlipidaemia. Its total attributable cost is estimated at £170–190 million, virtually all due to the cost of lipid-regulating drugs. This group is dominated by the statins—the National Service Framework on Coronary Heart Disease recommended their use and the total cost of such drugs dispensed increased more than three-fold between 1998 and 2002. They are now the most expensive drug group and their total cost is increasing at the fastest rate.[15]

20. In total the additional co-morbidities accounted for just over 20% of this estimate or £200–225 million. This is equivalent to around 40% of the difference between this estimate and the one in *Tackling Obesity in England*. The greater prevalence of obesity between 1998 and 2002 accounted for 12% of this difference and increased drug costs, take-up and availability a further 20%. It is not possible to say how much of the remaining increase was due other factors, like higher NHS costs or improved data.

21. Data from the 12 months to June 2003 show continuing significant increases in the cost of the drug groups that contribute most to the estimates above. Lipid-regulating drugs, anti-hypertensive therapy and drugs used in diabetes saw the three largest increases in total costs, up a combined 23%, or just under £300 million.[16] The implication of this for the costs of obesity is that the main element of expenditure is still increasing at a rapid pace, well above what might be expected from increases in the prevalence of these diseases alone.

All direct costs

22. The estimates in the previous two sections combine to give a total range for the direct costs of treating obesity and its consequences of £990–1,225 million (2.3–2.6% of net NHS expenditure in 2001–02), more than double the figure for 1998 given in *Tackling Obesity in*

15 Prescription Cost Analysis 2002, DH

16 Chief Executive's Report to the NHS 2002: Statistical Supplement, DH

England. All the limitations of that estimate apply to the updated version, specifically the exclusion of any social care data, incomplete data on primary care, reliance on international data on relative risk and the approximate nature of unit costs. All these must be considered when drawing any conclusions from these estimates. The lack of cost data in certain important areas and the number of associated diseases that have not been included means that these figures are still likely to underestimate the true cost of treating obesity and its consequences.

Indirect costs

Mortality

23. There is no need to include additional co-morbidities in the cost estimate for years of life lost as the NAO estimate used research that covered mortality from all causes. Applying the latest data on obesity rates by age and sex gives a figure of 34,100 deaths and around 45,000 attributable years of working life lost; an increase of 13% on the 1998 figures. Applying 2002 data on earnings[17] gives a total estimated cost due to premature mortality of £1.05–1.15 billion. This is an increase of around 20% on the 1998 figure from *Tackling Obesity in England*. This effect of higher wages and employment figures is broadly the same as the increased number of deaths resulting from higher obesity levels.

24. The overall number equates to 6.8% of deaths in England. While this is a significant number the World Health Organisation estimates that in developed countries 9.6% of deaths among men and 11.5% among women are due to overweight *and* obesity.[18] Applying these rates to deaths in England in 2001 gives a total of 52,500.[19]

Morbidity

25. Incapacity Benefit data was obtained from the Department for Work and Pensions on claimants with obesity and the other co-morbidities. This implied that there were 15.5–16 million attributable days of certified incapacity. This is equivalent to lost earnings of £1.3–1.45 billion—used as a proxy for production losses under the "human capital" approach. The range of this estimate goes from £20 million *less* than the 1998 figure to £130 million above. The estimated number of attributable days of incapacity is more than 10% below the estimate given for 1998, despite the inclusion of additional co-morbidities. Between 1998 and 2002 average daily earnings increased by 17.5%. The additional co-morbidities accounted for £190–210 million of this increase. The vast majority of this was for back pain. The relative risk of obese people developing back pain is quite small and only statistically significant for women. In these calculations only 5% of days of certified incapacity for lower back pain were attributable to obesity.

26. As indicated in *Tackling Obesity in England* the number of days of sickness attributable to obesity is an underestimate as it excludes self-certified days of sickness. This is counter-

17 Male and female average earnings in England adjusted for the national proportions of part-time working. *New Earnings Survey 2002*, ONS

18 The World Health Report 2002, WHO, table 4.9

19 Key population and vital statistics 2001, ONS

balanced by the fact that the obese group earns less than the national average wage figure used. It is not possible to say which of these factors is more important.

Conclusion

27. The following table combines all the estimates for 2002 and compares them to the 1998 figure. Overall this paper estimates that the cost of obesity in England was £3.3–3.7 billion in 2002. This is 27–42% above the figure given in *Tackling Obesity in England*; the midpoint is similar to its projection for 2010. It has been mentioned a number of times that a significant part of this increase is due to the inclusion of new co-morbidities in this analysis. An estimated £390–435 million of the increase was due to this. The remaining increase was due to a combination of increased drug costs, take-up and availability, improved data, higher NHS costs and higher earnings (in the economy as a whole) as well as an increase in the number of people who are obese. As has been indicated earlier, this total figure should still be seen as an underestimate.

The estimated cost of obesity in England: 1998 and 2002
£ millions

	1998 (NAO)	2002
GP consultations	6.8	12-15
Ordinary admissions	1.3	1.9
Day cases	0.1	.1
Outpatient attendances	0.5	0.5-0.7
Prescriptions	0.8	13.3
Total cost of treating obesity	**9.5**	**45.8-49.0**
GP consultations	44.9	90-105
Ordinary admissions	120.7	210-250
Day cases	5.2	10-15
Outpatient attendances	51.9	60-90
Prescriptions	247.2	575-625
Total cost of treating the consequences of obesity	**469.9**	**945-1,075**
Lost earnings due to attributable mortality	827.8	1,050-1,150
Lost earnings due to attributable sickness	1,321.7	1,300-1,450
Total indirect costs	**2,149.5**	**2,350-2,600**
Total cost of obesity	**2,628.9**	**3,340-3,724**

28. While this figure seems very large what does it really mean? Is it really that large? Some estimates for individual diseases are much higher. It is thought that diabetes and its co-morbidities consumes 9–10% of total NHS resources. The total (direct and indirect) costs of coronary heart disease and back pain have recently been estimated at £7.1 billion and £6.8 billion respectively.[20] Applying the method used in this paper the total cost of sickness absence due to depression is over £9 billion. The cost of smoking to the NHS in England was estimated at £1.4–1.7 billion in the mid-1990s, 4.3–5.3% of net spending.[21] In

20 Costs of selected diseases, 1999, UK www.heartstats.org

21 *Smoking Kills – White Paper on Tobacco (*Cm 4177); Department of Health Departmental Annual Report, various years.

this context the cost of obesity looks somewhat less significant. However, it is important to consider the rapid increase in obesity over the past two decades and the possibility that this might continue. The estimates of premature mortality due to obesity are significant in any context.

The future

29. This note only looks at future costs in a very general way. It is clear that, disregarding the additional co-morbidities, that changes in costs are not necessarily equal to changes in the prevalence of obesity. This is true even after general NHS inflation is accounted for. Other factors like new drugs, treatments and guidelines can radically increase costs. It is impossible to predict how these might alter the situation over the next decade. In addition to this there are further complicating factors. There is clearly a time lag between the onset of obesity and increases in related chronic diseases.[22] This suggests that further increases in health problems and economic costs are already 'locked in' and will increase. Similarly obesity can lead to diseases/conditions which are permanent—like gout and diabetes—while losing weight may help with their management health and cost implications remain. The rise in childhood obesity is likely to further multiply such effects as their exposure to risk is increased over a longer period.

Research and data

30. Data on relative risks of the associated diseases are largely international. This increases the uncertainty in cost estimates, especially when they are so reliant on the consequences of obesity. More research using data from the UK would improve the accuracy and credibility of such estimates. The methodology used for estimating costs is the best possible considering the available data, but it is not ideal. A number of simplifying assumptions have had to be made and methodologies vary for different types of costs. There is a severe lack of recent Department of Health/NHS estimates of the total costs of individual diseases/conditions. Some official estimates of the costs of the most important/expensive diseases and conditions would improve the public debate in this area and allow the burdens of a wide range to be put into a meaningful context.

22 Health at a Glance, OECD indicators 2003—Briefing note for the UK, OECD

Annex 2: Calculate your Body Mass Index

Body Mass Index Chart (English and Metric)[23]

To use find the intersection of your weight and height—this is your BMI.

Height (feet and inches)

Weight (pounds)	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"	Weight (kilograms)
100	20	19	18	18	17	17	16	16	15	15	14	14	14	13	13	12	12	45
105	21	20	19	19	18	17	17	16	16	16	15	15	14	14	13	13	13	47
110	21	21	20	19	19	18	18	17	17	16	16	15	15	15	14	14	13	50
115	22	22	21	20	20	19	19	18	17	17	17	16	16	15	15	14	14	52
120	23	23	22	21	21	20	19	19	18	18	17	17	16	16	15	15	15	54
125	24	24	23	22	21	21	20	20	19	18	18	17	17	16	16	16	15	57
130	25	25	24	23	22	22	21	20	20	19	19	18	18	17	17	16	16	59
135	26	26	25	24	23	22	22	21	21	20	19	19	18	18	17	17	16	61
140	27	26	26	25	24	23	23	22	21	21	20	20	19	18	18	17	17	63
145	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18	66
150	29	28	27	27	26	25	24	23	23	22	22	21	20	20	19	19	18	68
155	30	29	28	27	27	26	25	24	24	23	22	22	21	20	20	19	19	70
160	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20	19	72
165	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20	75
170	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	77
175	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	79
180	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	82
185	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23	84
190	37	36	35	34	33	32	31	30	29	28	27	26	26	25	24	24	23	86
195	38	37	36	35	33	32	31	31	30	29	28	27	26	26	25	24	24	88
200	39	38	37	35	34	33	32	31	30	30	29	28	27	26	26	25	24	91
205	40	39	37	36	35	34	33	32	31	30	29	29	28	27	26	26	25	93
210	41	40	38	37	36	35	34	33	32	31	30	29	28	28	27	26	26	95
215	42	41	39	38	37	36	35	34	33	32	31	30	29	28	28	27	26	98
220	43	42	40	39	38	37	36	34	33	32	32	31	30	29	28	27	27	100
225	44	43	41	40	39	37	36	35	34	33	32	31	31	30	29	28	27	102
230	45	43	42	41	39	38	37	36	35	34	33	32	31	30	30	29	28	104
235	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	29	29	107
240	47	45	44	43	41	40	39	38	36	35	34	33	33	32	31	30	29	109
245	48	46	45	43	42	41	40	38	37	36	35	34	33	32	31	31	30	111
250	49	47	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	114
	150	152.5	155	157.5	160	162.5	165	167.5	170	172.5	175	177.5	180	182.5	185	187.5	190	

Height (centimetres)

☐ Underweight ▒ Weight Appropriate ▒ Overweight ■ Obese

23 Source:www.slim-fast.com. Adapted from The National Institute of Health. NHLBI Clinical Guidelines on Overweight and Obesity June 1998. www.nhlbi.nih.gov/guidelines.

Annex 3: Nutritional and energy requirements

Estimated Average Requirements[24]

Age	Males (kcal)	Females (kcal)	Age	Males (kcal)	Females (kcal)
0-3 mo	545	515	11-14 yr	2220	1845
4-6 mo	690	645	15-18 yr	2755	2110
7-9 mo	825	765	19-50 yr	2550	1940
10-12 mo	920	865	51-59 yr	2550	1900
1-3 yr	1230	1165	60-64 yr	2380	1900
4-6 yr	1715	1545	65-74 yr	2330	1900
7-10 yr	1970	1740	74+ yr	2100	1810

Fat, protein and carbohydrate are the three nutrients that provide energy. Alcohol also provides energy. There is some evidence to suggest that a poor energy mix of the diet is a risk factor in various diseases such as coronary heart disease and certain cancers. The COMA panel reviewed this evidence and concluded that it would be useful to set DRVs[25] for total fat (fatty acids and glycerol), fatty acids, sugars and starches (Table 3)

Suggested population averages for protein, carbohydrate and fat as a percentage of dietary energy

	Diet containing alcohol[26]	Diet not containing alcohol
Protein	15	15
Total Carbohydrate	47	50
Non milk extrinsic sugars[27]	10	11
Total fat	33	35
Saturated fatty acids	10	11
Polyunsaturated fatty acids	6[28]	6.5
Trans fatty acids	2	2
Monosaturated fatty acids	12	13

24 ww.nutrition.org.uk

25 DRVs – Dietary Reference Values; EAR – Estimated Average Requirements

26 Alcohol should provide no more than 5% of energy in the diet

27 NMES – free sugar not bound in foods, eg table sugar, honey and sugars in fruit juices, but excluding milk sugar.

28 An individual maximum of 10% applies (with an individual minimum of 0.2% from linolenic acid, and 1% linolenic acid).

Approximate daily intakes for adults aged 19–50

	Males	Females
Protein[29]	55.5g	45g
Total Carbohydrate[30]	320g	245g
Fat[31]	95g	70g
Saturates	30g	20g
Sodium	2.5g	2g
Fibre	20g	16g
Sugar	70g	50g

29 *Dietary Reference Values for Food Energy and Nutrients for the UK*, Department of Health, 1991

30 Figure for carbohydrate calculated for the Committee by the FSA. Carbohydrates have not been included in Guideline Daily Amounts because these were thought to be less important than other categories for which GDAs were given, and potentially misleading.

31 Guideline Daily Amounts for fat, saturates, sodium, fibre and sugar taken from Williams C, Rayner M, Myatt M, Boag A, *Use your label – making sense of nutrition information*, MAFF, 1996

Annex 4: Energy inputs and outputs

	Nutritional content:[33]		Minutes required to burn off by activity:[32]		
	Calories	*Fat grams*	*walking slowly*	*walking mod. quickly*	*strenuous activity*
Snack Food					
Mars Bar (65g)	294	11.4	98	59	39
Popcorn (100g)	405	7.7	135	81	54
Entrees					
Big Mac (215g)	492	23	164	98	66
Cheeseburger	379	18.9	126	76	51
Kentucky Fried Chicken (67g)	195	12	65	39	26
Hamburger (108g)	254	7.7	85	51	34
Pizza Deluxe (1 slice/66g)	171	6.7	57	34	23
Pizza (‰ pizza/135g)	263	4.9	88	53	35
Potato Wedges (135g)	279	13	93	56	37
Bombay Potato (200g)	202	10.4	67	40	27
Chicken Korma (300g)	498	31	166	100	66
Chicken Tikka (150g)	232	6.2	77	46	31
Beverages					
Can of coke (330ml)	139	0	46	28	19
Pint of beer	182	0	61	36	24
Gin, 40% alcohol (25ml)	55	0	18	11	7
Sherry (50ml)	68	0	23	14	9
Wine (1 glass/120ml)	87	0	29	17	12
Vodka, 40% alcohol (25ml)	55	0	18	11	7

32 Total energy used by a man aged 25 years (weighing 65kg) to do various activities. Source: Ministry of Agriculture, Fisheries and Food (1992) Manual of Nutrition. HMSO, London

33 Source: www.weightlossresources.co.uk.

Total energy used by a man aged 25 years (weighing 65kg) to undertake variouus activities.[34]

	Average energy expenditure[35] *Kcal/min*	Minutes to burn off a 65g Mars Bar (294cal) 294 cal/*(Kcal/min)*	Minutes to burn a 215g Big Mac (492cal) 494 cal/(*Kcal/min)*
Everyday Activities			
Sitting	1.40	210	351
Standing	1.70	173	289
Washing, dressing	3.50	84	141
Walking slowly	3.00	98	164
Walking moderately quickly	5.00	59	98
Walking up and down stairs	9.00	33	55
Work and Recreation			
Light Activity (most domestic work, golf, lorry driving, carpentry, bricklaying)	2.5-4.9	79	133
Moderate Activity (gardening, tennis, dancing, jogging, cycling up to 20km per hour, digging)	5.0-7.4	47	79
Strenuous Activity (coal mining, cross-country running, football, swimming [crawl])	>7.5	39	66

34 In 2002, the average man in England was 174.8 cm tall, weighed 82.4 kg and had a BMI of 26.9.The average woman was 161.3 cm tall, weighed 69.5 kg and had a BMI 26.7.See "Body mass index, by survey year, age and sex," Adults 1993-2002 Table 6, Health Survey for England – Trend Data.

35 Source: Ministry of Agriculture, Fisheries and Food (1992) Manual of Nutrition. HMSO, London.

List of Abbreviations

ACT	Activity Co-ordination Team
ASA	Advertising Standards Authority
BHF	British Heart Foundation
BMI	Body Mass Index
CAP	Common Agricultural Policy
CHD	Coronary Heart Disease
DCMS	Department for Culture, Media and Sport
DEFRA	Department for Environment, Food and Rural Affairs
DfES	Department for Education and Skills
DfT	Department for Transport
DoH	Department of Health
FSA	Food Standards Agency
HEA	Health Education Authority
HFCS	High Fructose Corn Syrup
IOTF	International Obesity Task Force
LTP	Local Transport Plan
NAO	National Audit Office
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
ODPM	Office of the Deputy Prime Minister
OFCOM	Office of Communications
Ofsted	Office for Standards in Education
PCO	Primary Care Organisation
PCT	Primary Care Trust
PE	Physical Exercise
PSA	Public Service Agreement
RCGP	Royal College of General Physicians
RCP	Royal College of Physicians
SHA	Strategic Health Authority
TOAST	The Obesity Awareness and Solutions Trust
WHO	World Health Organization

Formal minutes

Thursday 10 May 2004

Members present:
Mr David Hinchliffe, in the Chair

Mr David Amess	Jim Dowd
John Austin	Mr Jon Owen Jones
Mr Keith Bradley	Dr Doug Naysmith
Mr Paul Burstow	Dr Richard Taylor

The Committee deliberated.

Draft Report (*Obesity*), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 411 read and agreed to.

Summary agreed to.

An Annex (*The economic cost of obesity*) agreed to.

Another Annex (*Calculate your body mass index*) agreed to.

Another Annex (*Nutritional and energy requirements*) agreed to.

Another Annex (*Energy inputs and outputs*) agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

[Adjourned till Thursday 6 May at 10.00 am.

Witnesses

Thursday 12 June 2003

Mr Mike Ash, Deputy Director, Planning Directorate, Office of the Deputy Prime Minister, **Ms Danila Armstrong**, Acting Nutrition Programme Manager, Cardiovascular Disease and Cancer Prevention, and **Ms Imogen Sharp**, Business Area Head, Department of Health, **Mrs Patricia Hayes**, Head, Charging and Local Transport Division, Department for Transport, **Mr Alec McGivan**, Director of Sport, Department for Culture, Media and Sport and **Ms Mela Watts**, Divisional Manager, Curriculum Division, Department for Education and Skills. Ev 23

Thursday 26 June 2003

Professor Sir George Alberti, President, International Diabetes Federation, **Dr Geof Rayner**, Chairman, UK Public Health Association, **Professor Julian Peto**, Institute of Cancer Research, **Professor Hubert Lacey**, Royal College of Psychiatrists, **Professor Jane Wardle**, Health Behaviour Unit, University College, London and **Dr Tim Barrett**, Consultant Paediatric Endocrinologist, Birmingham Children's Hospital Ev 58

Thursday 17 July 2003

Professor Andrew Prentice, MRC International Nutrition Group, London School of Hygiene and Tropical Medicine, **Dr Tim Lobstein**, Food Commission, **Professor Adrianne Hardmann**, Emeritus Professor, School of Sport and Exercise Sciences, University of Loughborough, **Dr Susan Jebb**, Head of Nutrition and Health Research, MRC Human Nutrition Research Centre and **Dr Nick Wareham**, Institute of Public Health, University of Cambridge. Ev 85

Thursday 18 September 2003

Thursday 30 October 2003

Thursday 6 November 2003

Thursday 13 November 2003

Thursday 27 November 2003

Thursday 4 December 2003

Thursday 18 December 2003

Thursday 8 January 2004

Thursday 15 January 2004

Thursday 11 March 2004

Monday 29 March 2004

List of written evidence

List of appendices to the Report contained in Volume III

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1	National Kidney Federation	OB 2
2	Royal College of Physicians of London	OB 3
3	Professor A Barnett	OB 5
4	Dr Mary Rudolf	OB 7
5	British Heart Foundation	OB 12
6	Roche	OB 15
7	Roche	OB 15A
8	CTC	OB 16
9	CTC	OB 16A
10	The Central Council of Physical Recreation	OB 17
11	UK Association for the Study of Obesity	OB 19
12	Counterweight	OB 23A
13	Nutrition Society	OB 24
14	Professor John Blundell	OB 76
15	Len Almond, Director of BHF National Centre for Physical Activity and Health	OB 26A
16	The Food Commission	OB 27A
17	Abbott Laboratories Ltd.	OB 30
18	The Royal College of General Practitioners	OB 31
19	Sport England	OB 32
20	Food and Drink Federation	OB 21
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23	Diabetes UK	OB 38
24	Child Growth Foundation	OB 40
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31	Womens Sports Foundation	OB 30
32	The Institute of Human Nutrition, University of Southampton	OB 56
33	Dr S McKenzie	OB 57
34	Focus on Food	OB 58
35	Royal College of Nursing	OB 62
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38	Welsh Food Alliance	OB 70
39	Sally Hayes and Emma Croft	OB 72A
40	Royal College of Psychiatrists	OB 77
41	The Headmaster, The Cathedral High School	OB 79
42	The Headmaster, Wakefield High School	OB 80
43	Wakefield West Primary Care Trust	OB 81
44	Department for Education and Skills	OB 86
45	Abbott Mead Vickers BBDO	OB 90A
46	Tesco	OB 97A
47	JT Winkler	OB 98
48	Slimming World	OB 105B
49	Mick Cooper	OB 108
50	Amanda Avery	OB 111A
51	Coronary Prevention Group and the International Obesity Task Force	OB 114
52	International Obesity Task Force	OB 115
53	Food Standards Agency	OB 116A
54	Move4Health	OB 119
55	Lloydspharmacy	OB 120
56	Department of Health	OB 8B
57	DCMS	OB 122
58	Coca-Cola	OB 101
59	DEFRA	OB 121
60	English Regions Cycling Development Team	OB 49
61	Centre for Social Marketing, University of Strathclyde	OB 123

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

Automatic Vending Association
Amateur Swimming Association
Department of Health
Infant and Dietetic Foods Association
Snack, Nut and Crisp Manufacturers' Association
Meat and Livestock Commission
Faculty of Public Health Medicine
Gillian Alderton

FMS Healthcare Ltd
Health Food Manufacturers' Association
The Sugar Bureau
Dr Peter Bundred and Professor Marion Hetherington
Obesity Management Association
Dr Krystyna Matyka
Federation of City Farms and Community Gardens
Periodical Publishers Association
Weightwatchers
Council of Heads of Medical Schools
The Biscuit Cake Chocolate & Confectionery Alliance
Professor David Benton
English Table Tennis Association
Rosemary Conley Diet and Fitness Clubs
British Gymnastics
National Heart Forum
Pixall Ltd
Anne Sheldon
Slim Fast Foods Limited
Living Streets
The Christchurch Obesity, Prevention Programme in Schools
The UK Weight Control Trial
Mr Andy Dixon
Canderel
Enuresis Resource and Information Centre
Slimming World
Mr Andrew Farmer
Dr C E Corney
Amanda Avery
Jackie Bushell
Cholesterol UK
Lloydspharmacy
Hilary Jackson

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 January 2010

Subject: Health Proposals Working Group - Update

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Introduction

1.1 At its meeting on 22 September 2009, the Scrutiny Board (Health) agreed to re-establish the Health Proposals Working Group (HPWG), with updated terms of reference.

1.2 In line with its terms of reference, the HPWG acts as a sub-group of the Scrutiny Board (Health) and aims to meet on a regular basis to allow local NHS bodies to inform Scrutiny members of potential changes to, and/or developments of, local health care services.

1.3 The HPWG held its first meeting of the current municipal year on 3 December 2009 and the draft minutes from that meeting are attached at Appendix 1.

1.4 After being deferred from the previous meeting (15 December 2009) – due to the draft minutes subsequently being unavailable, the purpose of this report is to present a summary of the issues discussed and seek endorsement from the Scrutiny Board (Health) on any proposed actions and/or recommendations.

2.0 Recommendations

2.1 Members are asked to consider the minutes of the HPWG (3 December 2009) and agree any proposed actions and/or recommendations therein.

3.0 Background Documents

- Terms of reference – Health Proposals Working Group (agreed 22 September 2009)

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APPENDIX 1

Scrutiny Board (Health)

Health Proposals Working Group

3 December 2009, 3.30 pm – 5.00 pm

NOTES OF MEETING

Attendance:

Members

Councillor Mark Dobson (Chair)
Councillor Sue Bentley
Councillor John Illingworth

Officers

NHS Leeds:
Nigel Gray (NG), Director of Commissioning & Development (Adult Services)
Carolyn Walker (CW), Communications Lead
Jane Westmoreland (JW), Head of Communications, Engagement and Diversity

Leeds Teaching Hospitals NHS Trust
Sylvia Craven (SC), Director of Planning

Leeds Partnerships Foundation Trust (LPFT)
Victoria Betton (VB),

Leeds City Council
John England (JE), Deputy Director, Adult Social Services
Steven Courtney (SMC), Scrutiny Support

Apologies:

Councillor Judith Chapman	Councillor David Hollingsworth
Councillor David Congreve	Councillor Graham Kirkland
Councillor Mohammed Iqbal	Councillor Paul Wadsworth
Councillor Lucinda Yeadon	Eddie Mack (Co-opted member)
Councillor Alan Lamb	

Items		Action
1	**Attendance / Introduction**	
	The Chair welcomed all those present to the first meeting (in the current municipal year) of the Health Proposals Working Group. Introductions were made and the apologies received were noted.	
2	**Terms of Reference**	
	The Terms of Reference for the working group, agreed by the Scrutiny Board (Health) on 22 September 2009, were presented and noted.	
3	**Minutes of previous meeting: 30 March 2009**	
	The minutes of the previous HPWG meeting held on 30 March 2009 were noted. It was also noted that these had been formally received and considered at the Scrutiny Board (Health) meeting on 28 April 2009.	
4	**Progress update on previous proposals**	
	Since its establishment, the Health Proposals Working Group has routinely received and considered progress updates against those service changes/ developments previously reported. A detailed update on the	

Items		Action
	following changes/ developments was presented to the meeting: • GP Led Health Centre • Urgent Care Commissioning Framework • Chapeltown and Harehills LIFT Joint Service Centres • Kirkstall Joint Service Centre • Additional dental services for Leeds A number of matters were raised and discussed in detail. The following points were raised: <u>GP Led Health Centre</u> • The Shakespeare Medical Practice and Walk-in Centre opened in March 2009. • At the end of October 2009 (8 months (approx.)) there were 823 registered patients (against a first year target of 1000) and had been 5452 walk-in consultations. • Through monitoring trends of attendance, patient registration was being actively encouraged. • Members queried whether there was any data around the avoidance of A&E attendance/ admissions as a result of the new centre being opened, and were advised that such work was starting to be done as part of the arrangements for monitoring the effectiveness of the emerging urgent care framework. • Members were reassured of the processes to ensure proper control for prescribing controlled drugs through walk-in centres. <u>Urgent Care Commissioning Framework</u> • The framework is a combination of NHS Direct providing telephony and triage services across the West Yorkshire region, with Local Care Direct providing the Leeds urgent treatment service. • The services went live on 1 April 2009 and, following some initial teething problems, were functioning well and meeting performance targets. • There had not been an increase in A&E attendance as a result of the new framework – although there were still some issues around some elements of the student population accessing A&E inappropriately. • There were some on-going connectivity/ technological issues around the use of mobile electronic recording devices in some areas – in particular, around the area of Otley. • Members were advised that an advertising campaign was being planned for the New Year in order to widely publicise the telephone access number that will enable patients to be given self-care advice or sign-posted to the most appropriate part of the health service for treatment.	
	<u>Chapeltown and Harehills LIFT Joint Service Centres</u> • A brief reminder of the background to the projects was presented. • It was reported that the buildings were expected to be completed by July 2010 (Chapeltown) and April 2010 (Harehills), approximately.	

Items	Action
Kirkstall Joint Service Centre • Advised that NHS Leeds' view of the service needs of the project had changed and that the NHS Leeds Board had therefore agreed not to proceed with the proposal. Changes included: o Plans for new housing had not materialised; o Improvements to GP service e-mails (i.e. extended services and extended hours); o A review of the need or desire for GPs in Kirkstall to move into the new development. One practice in particular has pulled out of the scheme after consulting with its patients; and, o A recent review of primary and community care services in the Kirkstall area, which highlighted no gaps in the provision of primary medical care services for local people. Feedback from patients and through existing assessments showed good access to local GP practices and that they deliver high-quality services. • The matter was being considered in some detail by the City and Regeneration Scrutiny Board. • Members expressed surprise at some of the comments which had not previously been factored into the plans and disappointment in relation to the considerable financial outlay by the Council Additional dental services for Leeds • An update on the increased provision was providing. This included increasing patient capacity by 20,000 permanent places across the following six localities: o Holt Park – opened on 10 November 2009 with an additional 4,000 patient places. o Horsforth – Thakker clinic due to open on 1 February 2010 offering an additional 2,000 patient places. o Garforth – Genix opened on 9 November 2009 with an additional 4,000 patient places o Wetherby – Keith Morris opened on 1 December 2009 with an additional 2,000 places. o Fearnville – Perfect Smile Clinic opened on 9 November 2009 with an additional 4,000 patient places o Wortley – Palmer & Patel's clinic due to open on 1 March 2010 offering an additional 4,000 patient places. • The permanent provision was supplemented by the following additional temporary (12 months) provision: o Clarendon Dental Spa based in North West Central Leeds providing care for 4000 patients; o Horsforth Smile Clinic in North West Leeds providing care for 2000 patients; and o Ross Dental Surgery in Guiseley (North West) providing care for 2000 patients. • Assurance was given that the correct number of dentists were in place in the correct locations, although actual patient numbers were not yet up to the desired levels. • Some issues still remain around the student population accessing services	

Items		Action
	Improved Mental Health Services for Older People • Proposals had initially been shared with the HPWG in October 2008: Further discussions had taken place in March 2009, where it was agreed that the proposals represented a significant (level 3) service change/development. • Currently plans are being developed for more formal engagement on the proposals. • Discussions around the financial framework were continuing and likely to be a key issue for the NHS Leeds Board in early 2010.	
	AGREED **(a) That the information presented be noted.** **(b) That the following matters were now substantively complete and should be removed from further update reports:** • **GP Led Health Centre** • **Urgent Care Commissioning Framework** • **Kirkstall Joint Service Centre** • **Additional dental services for Leeds**	**SMC/ JW**
5	**Transforming Community Services**	
	A report was presented outlining the nationally driven programme around Transforming Community Services. It was highlighted that this required all commissioners to describe how they intend to develop services provided in the community over the next 5 years. The following points were raised and discussed: • ***The NHS Leeds Community Services Commissioning Strategy 2009-2013*** ['the strategy'] describes why changes are necessary and how changes will be achieved for Leeds. • The strategy has been developed with direct input through NHS Leeds' Commissioning Executive, which includes practice based commissioners, local authority commissioners, clinicians and core commissioning expertise. • NHS Leeds Board approved the strategy in November 2009. • The strategy sets a framework for service change and identifies the following priority areas for development: o Healthy Living Services o Long Term Conditions Management o Care for Older People o Supporting Children and Families o Improving Sexual Health • The ultimate aim of the strategy was to provide services based on the needs of local areas. • Current arrangements were unsustainable and there would be a need to think differently about how services are provided in the future: Specific reference was made to long-term conditions and the role of specialist nurses.	

Items		Action
	• To help deliver the strategy, processes have started to further understand local needs, engage with partners, the public, patients, and clinicians to help review the current capacity and capability of existing providers. • It was recognised that the strategy offered an opportunity to deliver benefits to patients (by adopting a more 'patient centred' approach), however such opportunities would require different approaches to new technologies and workforce models when considering the redesign of services. • Consideration would also need to be given around integrating services (currently provided through different agencies) around the individual and how to utilise any efficiencies. • Under the umbrella of Transforming Community Services, any proposed service changes would include comprehensive and appropriate consultation with key stakeholders. **AGREED** **(a) That the information presented be noted.** **(b) That, under the umbrella of *Transforming Community Services*, a number of proposed service changes or reconfigurations were likely to be brought forward: These would need to be identified as early as possible to ensure the timely engagement and involvement of all key stakeholders, including the Scrutiny Board (Health).**	**NG/ JW**
6	**Breast Screening Service**	
	Members were advised that: • The breast screening service is jointly commissioned from Leeds Teaching Hospitals NHS Trust by NHS Leeds and NHS Wakefield District. • In Leeds, the service is currently delivered via two mammography machines at St James's Hospital and four mobile units, which deliver the routine breast screening programme. • As part of the Cancer Reform Strategy, important changes to breast screening services across the UK are required by 2012. The first of these changes would see the introduction of digital mammography equipment to replace existing analogue machines – which would help to: o increase the screening age range so women aged 47 to 73 are eligible for breast screening (current age range is 50 to 70); and o provide routine breast screening for women outside of the screening age range who have a family history of breast cancer. • To help achieve the requirements of the Cancer Reform Strategy, there would be an extension to the existing breast screening service currently provided in Leeds. • NHS Leeds and NHS Wakefield District were planning to run separate consultations on the local development of breast screening services – due to the proposals being different for the two different areas. • To introduce the outlined improvements, the changes are being planned for Leeds, including:	

Items		Action
	○ Introduction of routine breast screening using existing digital equipment at Wharfedale General Hospital in Otley: This will make maximum use of the current service which is currently only for women with breast symptoms. ○ Reduction in the number of mobile units from four to two and increase the number of mammography machines at static sites: This will provide a total of four digital mammography machines on static sites and two digital mobile units providing the breast screening service. More women can be screened at static sites than on mobile units, which will help us to improve screening outcomes and extend the age range for routine screening. • Once routine screening is introduced on the existing machine at Wharfedale, there will be three machines in total (on static sites) delivering the service for Leeds: NHS Leeds is proposing to seek the views of service users and members of the public on the location of an additional mammography machine. The options are to site the new machine: ○ At St James's Hospital along with two of the existing machines; or ○ At an inner west location in an NHS facility, to be determined. (NHS Leeds are currently appraising the suitability of health facilities in inner west Leeds, including health centres (should this be the outcome of the consultation)). • As an interim measure, NHS Leeds is also in the process of discussing with LTHT the provision of an additional digital mammography machine at St James's Hospital on a short-term basis: This would represent the most value for money option for an interim solution, with minimum enabling works necessary, and is also the only static service in Leeds with room for expansion. • An interim solution would help to ensure the earlier phasing in of the extended age range for breast screening – probably around April 2010: The outcome of the discussion with LTHT will be communicated with the Health Proposals Working Group. Members raised issues around transport links to SJUH from other areas of the City, particularly in terms of the impact on patients travelling from the west of the City. **AGREED** **(a) That the proposed changes to the breast screening service in Leeds represent a significant variation in services.** **(b) That the proposals warrant a level three involvement and engagement process that will include a range of engagement activities to involve current and future service users / carers, the public and the active engagement of the voluntary sector.**	**NG / JW** **NG/ JW**
7	**Leeds Teaching Hospitals NHS Trust: Update on proposed service moves/ changes**	
	Reference was made to a letter (dated 26 October 2009) sent to the Chair of the Scrutiny Board (Health) and circulated to other Scrutiny Board members. The main areas covered in the letter included: • Clinical Services Reconfiguration (CSR) • Gastroenterology inpatients	

Items	Action
• Hepatology inpatients • General surgery inpatients • Blocks on the Seacroft hospital site • Dermatology and Rheumatology <u>Clinical Services Reconfiguration (CSR)</u> • Members were reminded of the most recent update provided on the proposed moves associated with CSR and the centralisation of Children's inpatient services at LGI. • Members were advised that, in terms of updates and information for the public, an 8-page insert was to be included with the Council's residents newsletter. <u>Gastroenterology inpatients</u> • Members were reminded of the proposal to centralise 15 beds currently at SJUH on the same site as the 30 beds currently at LGI. • This was first raised with Scrutiny Board in February 2007 as part of CSR, and the move is likely to take place within the first 4 months of 2010. <u>Hepatology inpatients</u> • The proposed move of ward 71 in Lincoln Wing SJUH to a vacant ward (83) in the new Bexley Wing on the SJUH site had now taken place. It was noted that the new ward had more beds than ward 71. <u>General surgery inpatients</u> • Members were advised of a general plan within the Trust's Surgical Directorate to enhance patient safety and the patient experience. This will involve some pathway redesign that will maintain activity and improve efficiency. The overall impact will result in reducing bed numbers across the directorate from 210 to 200. • With all the changes are likely to be in place by 4th January 2010, Members were reminded that the Trust's Surgical Directorate at SJUH comprised urology, general surgery, elective and acute, pancreatitis, upper GI pancreatic cancer, upper GI benign surgery, liver transplantation, liver cancer and thoracic surgery across 8 wards. <u>Blocks on the Seacroft hospital site</u> • Members were advised that to manage what is a very sprawling site more appropriately, the site has been divided into 3 zones. • Zone 3 was the area containing all the good quality buildings and it is proposed to move any staff and services still in zones 1 and 2 into zone 3 or if more appropriate, to another site. As each block closes it will be 'de-recognised' , which will involve making each block safe and remove the need for continued facilities such as background heating, lighting etc. and thus reducing costs. • While it was not envisaged that any clinical services will need to move off the site, members were assured that should direct patient services need to move, appropriate engagement will take place. • It was suggested that more information be brought back to the Scrutiny Board once the project had been scoped further.	

Items		Action
	Dermatology and Rheumatology • Members were reminded of the significant discussion on dermatology services at the Scrutiny Board in November 2009. At that meeting the Trust had given a firm commitment to engage with service users in developing future proposals. • Members were advised that a sub-specialism within rheumatology was due to be stopped. This was due to the imminent retirement of a consultant specialising in that field – with no replacement available. Members were advised that this involved very small patient numbers (600 in total), with 60% residing outside the Yorkshire and the Humber area.	
	AGREED **(a) That the information presented be noted.** **(b) That further details of proposed changes to the Seacroft site be presented to the Scrutiny Board (Health) in due course.**	
8	**Eccleshill Independent Sector Treatment Centre**	
	Members were advised that NHS Bradford and Airedale, in partnership with NHS Leeds, was currently conducting a formal tender process for the continuation of a range of healthcare services at the Eccleshill Independent Sector Treatment Centre (ISTC). Due to the imminent end of the current contract, the formal tender process began in August 2009: The tendering process is being conducted in accordance with procurement law in order to ensure a fair and robust process and that the best range of services is provided for patients. Members sought reassurance around the centre, the services provided and the nature of the contract. In response, Members were advised that the centre provided a range of day-case and diagnostic services, which were contracted on a 'block contract' basis: However this was set to change to a 'cost per case' contract from April 2010. Reference was subsequently made to the recent YEP article on the Eccleshill Independent Sector Treatment Centre (ISTC), published on 1 December 2009 and a letter from the NHS Leeds' Acting Chief Executive to the Editor of the YEP in response. A copy of the letter was circulated, which highlighted: • Patient safety remains a top priority for the NHS and all its care providers and the centre is fully licensed to provide the services commissioned from it. • Patients have shown high levels of satisfaction, with over 98% being satisfied with the treatment and care provided at the centre. • The published article made reference to a Healthcare Commission (now the Care Quality Commission) report: However, this was not the most up to date report on the quality of services provided at the centre and since that report, a number of reviews had taken place. • Recent reviews (including the most recent in November 2009 by the Care Quality Commission) demonstrate that the centre is well	

Items		Action
	regulated and is a safe to provide treatment. • Following the death of Dr Hubley in 2007, a series of actions had been taken by the centre and commissioners to ensure patient safety: This included the suspension of keyhole surgery in 2007 – which is no longer commissioned from the centre. The coroner had confirmed he was satisfied with the remedial steps taken. Notwithstanding the recent press coverage, it was outlined that, following several discussions between NHS Bradford and Airedale and the Department of Health (DH) Procurement Team, it had been agreed that, as the new contract would be a straightforward like-for-like re-provision of the services currently provided, this did not represent a proposed change to the level of service: However, in the spirit of openness, the proposed re-provision at the centre was being reported to the working group.	
	AGREED **That the information presented be noted.**	
9	**Windmill Health Centre (verbal report)**	
	Not discussed. **AGREED** **That a written note / report is circulated to members of the Working Group.**	**JW / SMC**
10	**Summary Care Records (verbal report)**	
	Not discussed. **AGREED** **That a written note / report is circulated to members of the Working Group.**	**JW / SMC**
11	**NHS Constitution (verbal report)**	
	Not discussed. **AGREED** **That a written note / report is circulated to members of the Working Group.**	**JW / SMC**
12	**Horizon scanning**	
	Not discussed.	
13	**Any other business**	
	No other business identified.	
	Future meetings dates It was agreed that potential future meeting dates would be identified	**SMC**

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 January 2010

Subject: Leeds Teaching Hospitals NHS Trust – Foundation Trust Consultation: Scrutiny Board Submission

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose of this Report

1.1 The purpose of the report is to present the Scrutiny Board's submission issued to LTHT in response to the consultation around the Trust's initial proposals to become an NHS Foundation Trust.

2.0 Background

2.1 NHS Foundation Trusts are a new type of organisation, they are not-for-profit, public benefit corporations: They remain part of the NHS and must meet national healthcare standards, and continue to provide services to patients on the basis of need and not ability to pay.

2.2 At its meeting in November 2009, the Scrutiny Board was formally advised that LTHT is in the process of developing its application for this important change. The Scrutiny Board was also informed that, under section 35(5) of the National Health Service Act 2006, LTHT is required by to undertake formal consultation with the staff, patients, the public and stakeholder bodies.

2.3 The Scrutiny Board was presented with a copy of LTHT's consultation document that set out the full range of issues involved in the Trust's application and was provided with an indicative timetable for the Trust to achieve Foundation Status. Details of the Trust's consultation plan were also presented.

2.4 Following a lengthy and detailed discussion with the Trust's Chief Nurse regarding the proposals, the Scrutiny Board requested that the Principal Scrutiny Adviser prepare a draft consultation response, summarising the comments made by the Scrutiny Board, for submission to the Leeds Teaching Hospitals NHS Trust as part of the consultation process.

3.0 Foundation Trust – consultation response

3.1 At its meeting on 15 December 2009, the Scrutiny Board was advised that, due to other priorities, a formal consultation response had yet to be drafted: As the deadline for consultation responses was before the next meeting of the Board, it was agreed to circulate a summary of the Board's conclusions via email for Members approval.

3.2 An initial draft response was issued to members of the Scrutiny Board on 23 December 2009: A revised response was issued to LTHT as the Board's formal submission on 8 January 2010. This is attached at Appendix 1.

4.0 Recommendation

4.1 Members of the Scrutiny Board are asked to formally endorse the consultation response submitted.

5.0 Background Papers

Your Hospitals, Yours Say: LTHT Consultation Document – October 2009
Scrutiny Board (Health): *Leeds Teaching Hospitals NHS Trust – Foundation Trust Consultation* (24 November 2009)

APPENDIX 1

Scrutiny Board (Health)

Leeds Teaching Hospitals NHS Trust

Foundation Trust Consultation Document – Formal Response

1	**Overall, do you support our plans to become a Foundation Trust?**
	We support the aspiration to achieve Foundation Trust (FT) status and agree that greater involvement of local communities in shaping local health services is a positive step forward. Nonetheless, at this moment in time, we do not believe there is sufficient evidence to demonstrate that LTHT have the necessary organisational competencies or track record to deliver many of the commitments offered in the consultation document – particularly around involvement and engagement. Regrettably, we have grave reservations in supporting LTHT's current application for FT status. Please see our additional comments in this regard. However, to help the LTHT develop any future proposals for FT status, we would offer the following comments based on the proposals set out in the consultation document '*your hospitals, your say*'.
2	**Do you think the proposed name properly says what we are about?**
	Yes. However, we believe much more work is needed to help the wider population understand the significance of FT status.
3	**Do you have any suggestions you think we should take into account as part of our vision and goals?**
	See our additional comments.
4	**Do you support the proposal that staff Members automatically become Members unless they choose to opt out?**
	We neither support nor oppose this proposal.
5	**Do you agree with the minimum age of 16 for Members?**
	Overall, yes. However, as we look forward to the completion of the Clinical Services Reconfiguration – which will see the centralisation of Children's in-patient services at Leeds General Infirmary, we recognise the significant level of resources necessary to provide the range of treatments and services for Children. Therefore, we believe it is important that children and young people are fully engaged in the ongoing development of services in this area. As such, we would recommend that as part of any future proposals, consideration is given to establishing a governor role (with supporting infrastructure) that ensures the views of children and young people are adequately captured and represented at the Board of Governor level.
6	**Please let us know if you know of any 'seldom heard' (or hard to reach) groups and tell us about any effective ways to communicate with them.**
	See our comments above (question 5), regarding children and young people. We also recommend that further advice is sought from the Council's equalities unit in this regard.

APPENDIX 1

Scrutiny Board (Health)

Leeds Teaching Hospitals NHS Trust

Foundation Trust Consultation Document – Formal Response

7	**Do you think we have the right number of Governors? Please let us know if you think there are parts of the local community or partner organisations that are not represented.**
	As the main non-NHS local health community partner, we believe that Leeds City Council should be allocated more than one appointed governor, as proposed. Also see our response to Q12.
8	**Is 3 years the right term of office for Governors?**
	A 3-year term of office for governors is in line with the other foundation trust (Leeds Partnerships NHS Foundation Trust) operating in Leeds. As such, we do not oppose this aspect of the proposal, although an alternative approach could be a 4-year term of office with elections every 2 years (i.e. changing 50% of the governors every 2 years).
9	**Do you think our proposals for Governor roles will help us to deliver health care effectively?**
	As stated in Q1, we support the aspiration to achieve FT status and agree that greater involvement of local communities in shaping local health services is a positive step forward. We believe that the proposals around governor roles have the potential to help deliver health care effectively: However, given our recent experiences around the management of proposed changes to renal and, to a lesser degree, dermatology services, we have grave reservations in supporting LTHT's application at this time, and would question the Trust's capacity and capability to provide sufficient support to develop the role of governors effectively. We believe that further work is needed to help demonstrate the Trust's competency in this area.
10	**Do you think these are the right groups for staff constituencies?**
	We agree that the active involvement and engagement of staff is a crucial element of the proposal, however we neither support nor oppose the proposed staff constituencies.
11	**Should volunteers be regarded as Members of staff?**
	We understand that volunteers can provide an important additional resource in the overall delivery of health care services. However, it is difficult for us to provide a view on whether volunteers be regarded as Members of staff, as we do not have any information on the terms of engagement for volunteers and how such terms may differ from members of staff. Nonetheless, it is important for volunteers to have an appropriate mechanism through which they can be actively involved and engaged in the election process: We believe this can be achieved equally through electing a staff governor or a public governor. In addition, we believe it is equally important that mechanisms exist for volunteers to be actively involved and engaged on an ongoing basis. It is essential that volunteers recognise that such mechanisms are in place and they have a point of contact within the governor structure. This could be an explicit role for the non-clinical staff governor voice.

APPENDIX 1

Scrutiny Board (Health)

Leeds Teaching Hospitals NHS Trust

Foundation Trust Consultation Document – Formal Response

<table>
<tr><td>12</td><td>Do you think these boundaries for the public constituencies fairly represent areas of Leeds?</td></tr>
<tr><td></td><td>No. As democratically elected representatives of local communities across Leeds, we do not recognise the proposed public constituencies. We appreciate the practicalities that are likely to be associated with providing support for a large number of governors and that mirroring the 33 electoral wards, with 2 governors per ward, is perhaps unfeasible. However, for a number of years the Council has been operating a system of area management – aimed at improving localities and delegating responsibilities and functions to a more local level. This system of devolved decision-making is delivered through grouping electoral wards to form 10 area committees. We believe that this structure / grouping of electoral wards provides a more logical approach to assembling a smaller and more manageable number of public constituencies. We also believe that, by mirroring the grouping of electoral wards already established under the area management arrangements, there will be greater public affiliation than under those proposed.

As such, we would recommend the following groupings (as set out by the Council's area management arrangements):

<table>
<tr><th>Constituency</th><th>Electoral wards included</th></tr>
<tr><td>North West (Inner)</td><td>Headingley, Hyde Park & Woodhouse, Kirkstall, Weetwood</td></tr>
<tr><td>North West (Outer)</td><td>Adel & Wharfedale, Guisley & Rawdon, Horsforth, Otley & Yeadon</td></tr>
<tr><td>North East (Inner)</td><td>Chapel Allerton, Moortown, Roundhay</td></tr>
<tr><td>North East (Outer)</td><td>Alwoodley, Harewood, Wetherby</td></tr>
<tr><td>East (Inner)</td><td>Burmantofts & Richmond Hill, Gipton & Harehils, Killingbeck & Seacroft</td></tr>
<tr><td>East (Outer)</td><td>Crossgates & Whinmoor, Garforth & Swillington, Kippax & Methley, Temple Newsam</td></tr>
<tr><td>South (Inner)</td><td>Beeston & Holbeck, City & Hunslet, Middleton Park</td></tr>
<tr><td>South (Outer)</td><td>Ardsley & Robin Hood, Morley North, Morley South, Rothwell</td></tr>
<tr><td>West (Inner)</td><td>Armley, Bramley & Stanningley</td></tr>
<tr><td>West (Outer)</td><td>Calverley & Farsley, Farnley & Wortley, Pudsey</td></tr>
</table>

In line with the current proposals, we recommend that 2 representatives from each of the above public constituencies be elected to serve as governors. These appointments would be in addition to the 'regional' and 'rest of England' governors proposed in the consultation document.</td></tr>
<tr><td>13</td><td>Is this the right number of public constituencies?</td></tr>
<tr><td></td><td>See our response to Q12.</td></tr>
</table>

Scrutiny Board (Health)

Leeds Teaching Hospitals NHS Trust

Foundation Trust Consultation Document – Formal Response

14	**Do you think we should have separate groups specifically representing patients? If so, how might we break them down into smaller groups?**
	We are also aware that a number of patient groups already exist, with many aiming to work closely with clinical teams across the Trust to help improve patient care. However, our recent experience has led us to conclude that significant improvements are needed in this area. We believe that, currently, there is insufficient evidence to demonstrate that LTHT has the organisational competencies to deliver many of the commitments presented in the consultation document – particularly around involvement and engagement. We accept that by having public constituency governors, there is significant potential for current and/or prospective patients to contribute to the development of local health care services. However, given our recent experience, we would welcome any proposals that will develop and strengthen the Trust's arrangements for engaging and involving patients more explicitly. This could, for example, include a specific role for the Patient Advice and Liaison Service within any future arrangements.
15	**Do you think our proposals for appointed Governors are right?**
	See our response to Q7.
16	**Do you agree with the restrictions on who can become a Governor?**
	We agree with the restrictions presented in the consultation document.
17	**Do you agree with our proposals for the Board of Directors?**
	We are in broad agreement with the proposals for the Board of Directors, as presented in the consultation document. However, as the main non-NHS local health community partner, we believe consideration should be given to allocating Leeds City Council a Non-Executive Director role on the Board of Directors.
18	**Do you agree with our proposed transitional arrangements?**
	The transitional arrangements seem reasonable, however given our serious reservations regarding the Trust's ability to deliver against its aspirations, we would question the proposed timescales (i.e. governor elections in 2010).
19	**Do you agree that elections should be twice every three years, involving around half of the elected Governors?**
	See our response to Q8.

Please see our additional comments (below).

APPENDIX 1

Scrutiny Board (Health)

Leeds Teaching Hospitals NHS Trust

Foundation Trust Consultation Document – Formal Response

Additional comments

There are two recent experiences around proposed service changes that we believe are particularly pertinent to the current consultation on the Trust's proposals to achieve FT status.

Renal Services

The following points have been extracted from our agreed statement on Renal Service in Leeds (December 2009):

Foundation Trust Status

106. In November 2009, we also heard about LTHT's proposals and associated processes for achieving Foundation Trust (FT) status.

107. We considered the FT proposals in detail and hope to provide a separate consultation response in due course. However, there are some aspects of the FT proposals and consultation document which, in our view, are very pertinent to the issues and circumstances associated with renal services.

108. The consultation document is entitled 'Your hospitals, Your say' and it is interspersed with references about the benefits of being a Foundation Trust, such as:

- *'greater freedom to develop services'*
- *'more accountable to the local community'*
- *'able to tailor local services to the needs of local people'*

109. The consultation document also details a number of commitments that LTHT would sign up to as a Foundation Trust, including:

- *asking the views of members*
- *tailoring services*
- *supporting patient choice*
- *involving local communities*
- *working more closely with other bodies*
- *strengthening contractual arrangements with other organisations*

110. However, based on our recent experiences and the evidence identified in this statement, we believe that at the present time, these fine words are just that – fine words.

111. We would all support these statements of intent, and agree that greater involvement of local communities in shaping local health services is a positive step forward. Nonetheless, at this moment in time, we do not believe there is sufficient evidence to demonstrate that LTHT have the necessary organisational competencies or track record to deliver such commitments. As such, we have grave reservations in supporting LTHT's application for FT status.

112. LTHT has an annual budget approaching £800 million and we firmly believe that the public of Leeds and the surrounding areas deserve to be reassured about the management and organisation of LTHT – including key business processes. We believe that such reassurance needs to be provided prior to any further devolvement of power and increased autonomy.

A copy of the Scrutiny Board's statement is attached for reference purposes.

Dermatology Services

In early October, we became aware of potential changes in the provision of dermatology services, particularly in terms of inpatient provision on ward 43 at Leeds General Infirmary (LGI). When the potential changes first emerged we received two separate requests for the proposals to be examined in more detail. These, independent, requests came from patients and users of the dermatology service and the British Association of Dermatologists (BAD).

As such we considered the issue in more detail at our meeting in November 2009 and heard from a range of interested parties, including representatives from LTHT, dermatology patients and the BAD. After hearing from all the parties represented at that meeting we made the following comments:

- We were not averse to changes in services but an emerging theme for the year to date, seemed to be around how changes are proposed and progressed.
- We were concerned that the Chief Executive of LTHT had already indicated that ward 43 was not suitable as a ward and would be turned into office space and despite the assurances given at the meeting, it seemed that a decision had already been taken to move services from Ward 43.
- We were again concerned about the lack of consultation by LTHT with key stakeholders and that the Trust did not seem to have a strategy or procedure for consultation.
- We believed that the changes represented a substantial variation in service and as such should be the subject of a 12 week period of consultation, in which the Scrutiny Board should be included. Substantial variations also could not be looked at in terms of money but on the basis of clinical need.
- We agreed that this issue should come back to the Scrutiny Board to ensure that the commitments given by LTHT regarding the consultation process were taking place.

January 2010

Leeds CITY COUNCIL

Originator: Steven Courtney

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Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 January 2010

Subject: Updated Work Programme 2009/10

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose

1.1 The purpose of this report is to present and update members on the current activity across a number of work areas and present an outline work programme. The Board is asked to consider, amend and agree its work programme, as appropriate.

2.0 Background

2.1 At its meeting on 30 June 2009, the Board received a number of inputs to help members consider the Board's priorities during the current municipal year. This included specific inputs from:

- Executive Board Member for Adult Health and Social Care
- Deputy Director (Adult Social Services)
- NHS Leeds
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Leeds Partnerships Foundation Trust (LPFT)

2.2 At that meeting a number of potential work areas were identified by members of the Board. These potential areas were confirmed in a further report, along with an outline work programme, presented at the Board meeting held on 28 July 2009.

2.3 Subsequently, the outline work programme, including any emerging issues, is routinely presented to the Scrutiny Board for consideration, amendment and/or agreement: The work programme was previously presented and agreed at the Scrutiny Board meeting held on 15 December 2009.

3.0 Update on specific work areas and associated activity

3.1 At the meeting held on 20 October 2009, the Scrutiny Board was presented with a comprehensive update across a range of matters under the Board's consideration: This section of the report seeks to provide a similar update.

<u>The role of the Council and its partners in promoting good public health – Scrutiny Inquiry</u>

3.2 At the previous meeting (22 September 2009), members of the Scrutiny Board (Health) agreed terms of reference for the above inquiry. In this regard, the Board agreed to consider arrangements relating to four specific areas of public health.

3.3 The first session of the inquiry took place in October 2009, with the second session (in part) taking place at the previous meeting on 15 December 2009. However, as the Board's discussion around obesity and levels of physical activity remained incomplete, it was agreed to carry over some aspects of that session to the January 2010 meeting: Issues around obesity and levels of physical activity have been considered elsewhere on the agenda.

3.4 However, there has been some significant slippage against the originally agreed timetable. As such, a revised timetable to complete the inquiry is as follows:

- Alcohol consumption – February 2010;
- Smoking and any other outstanding matter identified by the Scrutiny Board – undertaken through an appointed working group (to be agreed);
- Completed inquiry report agreed April / may 2010.

<u>Renal services in Leeds</u>

3.5 The Scrutiny Board had two substantive discussions (July 2009 and November 2009) around proposed changes in the provision of renal services - particularly in terms of provision at Leeds General Infirmary.

3.6 In response to the evidence presented, at the meeting on 15 December 2009 the Scrutiny Board agreed a statement, which included a number of specific recommendations for various bodies and organisations.

3.7 For information, a copy of the final statement is attached at Appendix 1: This has been issued to each of the bodies/ organisations identified in the recommendations, in addition to other interested parties such as:

- The local Kidney Patients Associations
- Other Health Scrutiny Chairs across the region (Yorkshire and the Humber)
- Leaders of the main political groups (Leeds City Council)
- Executive Board member for Adult Health and Social Care
- Local Members of Parliament (MPs)

3.8 Some initial responses have been received: These include responses from the Strategic Health Authority (NHS Yorkshire and the Humber), Leeds Teaching Hospitals NHS Trust (LTHT) and Specialised Commissioning Group (Yorkshire and the Humber).

3.9 A further report, including specific responses to each of the recommendations highlighted in the Scrutiny Board's statement, will be presented to the Board as soon as practicable.

Provision of dermatology services at Ward 43 (Leeds General Infirmary (LGI))

3.10 Following consideration of the proposed changes at the meeting on 24 November 2009, the Scrutiny Board highlighted a number of concerns regarding the proposals and how these had been progressed at that time.

3.11 A letter from the Chair of the Scrutiny Board, has subsequently been issued to the Chief Executive of LTHT seeking clarification and reassurance on a number of areas: Not least, the process for continued and meaningful engagement with key stakeholders in developing future plans for delivery of the service.

3.12 A report on progress and any further development will be provided to the Scrutiny Board in due course and before the end of the current municipal year.

Use of 0844 Numbers at GP Surgeries

3.13 Following the update presented in October 2009, there have been no further developments. However, this remains an area where the Scrutiny Board will maintain a watching brief.

Health Proposals Working Group

3.14 The working group held its first meeting on 3 December 2009: The draft minutes from that meeting are presented elsewhere on the agenda.

3.15 A further meeting of the working group will take place later this year (most likely March 2010), although a precise date is yet to be agreed.

Openness in the NHS

3.16 The Department of Health publication 'Code of Practice on Openness in the NHS' (2003) sets out general principals for open and transparent decision-making within local NHS bodies.

3.17 In order to attempt to better understand how each of the local NHS Trusts interpret and implement the national guidance, Members will recall that, in August 2009, the Chair of the Scrutiny Board wrote to each Trust in this regard.

3.18 Following the update presented in October 2009, there have been no further developments: However, this remains an area of interest and further updates will be provided in due course.

Children's cardiac and neurosurgery services – national reviews

3.19 In September 2009, members of the Scrutiny Board were made aware of a national review of Children's Cardiac Surgery Services currently being undertaken. In October 2009, members of the Scrutiny Board were also made aware of a national review of Children's Neurosurgery Services.

3.20 At the October 2009 Scrutiny Board meeting, members were advised of the proposed timescales for each review and reminded that both Children's Cardiac

Surgery Services and Children's Neurosurgery Services are provided by Leeds Teaching Hospitals NHS Trust.

3.21 In November 2009, the Chair of the Board attended a national stakeholder event in relation to the review of Children's Neurosurgery Services: Leeds City Council was the only local authority represented at the event.

3.22 The Chair of the Scrutiny Board has subsequently written to both the national team leading the reviews and, more locally, the Specialised Commission Group (Yorkshire and the Humber), seeking clarification around the involvement and engagement work with all key stakeholders – in particular local Health Overview and Scrutiny Committees. In order to keep other appraised of development, this recent correspondence has been shared with all other Health Scrutiny Chairs across the region (Yorkshire and the Humber).

3.23 Reports on developments and further updates will be provided to the Scrutiny Board in due course.

Quality Accounts

3.24 In June 2008, through the publication of the outcome of Lord Darzi's next stage review of the NHS (*High Quality Care for All*), the Government set out a new Quality Framework for all providers of NHS services: A key component of this framework is the requirement for all providers of NHS services to publish Quality Accounts: an annual public report on the quality of health care services delivered.

3.25 In this regard, a letter from the Department of Health has recently been received which sets out the roles of Commissioning Primary Care Trusts (PCTs), Local Involvement Networks (LINks) and local authority [Health] Overview and Scrutiny Committees (OSCs). A copy of the letter received is attached at Appendix 2.

3.26 In the absence of final regulations, the letter sets out some key issues for the Scrutiny Board to consider, including:

- Timescales for the production of Quality Accounts;
- Details of those service providers required to produce Quality Accounts in the first year (i.e. by June 2010);
- Details of the statutory role of commissioning PCTs
- An outline of the voluntary, and potentially complementary, roles of the Leeds LINk and the Scrutiny Board (Health)

3.27 Given the recently established arrangements for reporting performance to the Board, the potential role of the Scrutiny Board could be seen as a useful extension to such arrangements in the current year and for the future. In this context, preliminary discussions between local NHS Trusts and the Principal Scrutiny Adviser have taken place regarding the potential role of the Scrutiny Board and the timing of any such input.

3.28 It is likely that further discussions with local NHS Trusts are required, alongside any discussions with Leeds LINk: Members of the Scrutiny Board are asked to offer and agree any opinion which may help in any further discussions.

4.0 Work programme (2009/10)

4.1 A revised outline work programme is presented at Appendix 3 for consideration.

4.2 For information, the minutes from the Executive Board meetings held on 9 December 2009 and 6 January 2010 are attached at Appendix 4 and Appendix 5, respectively. The Scrutiny Board is asked to consider these minutes within the context of making any adjustments to its work programme.

4.3 Members will be aware that the outline work programme should be regarded as a 'live' document, which may evolve and change over time to reflect any in-year change in priorities and/or emerging issues. As such, the Scrutiny Board is asked to consider the attached outline work programme for the remainder of the year and agree / amend as appropriate.

5.0 Recommendations

5.1 Members are asked to consider the details presented in this report and:

5.1.1 Agree the arrangements and revised timetable for completing the scrutiny inquiry around '*The role of the Council and its partners in promoting good public health*';

5.1.2 Note the updated information presented and need for further updates/ reports (as appropriate) around the following matters:

- Renal services in Leeds
- Provision of dermatology services
- Use of 0844 Numbers at GP Surgeries
- The Health Proposals Working Group
- Openness in the NHS
- Children's Cardiac and Neurosurgery Services – national reviews

5.1.3 Consider the information presented around 'Quality Accounts' and agree any matters that may usefully help further discussions around the Board's future role in this regard; and,

5.1.4 Consider the outline work programme attached at Appendix 3 and agree / amend as appropriate

6.0 Background Documents

- Scrutiny Board (Health) – Updated Work programme (20 October 2009)
- Scrutiny Board (Health) – Updated Work programme (24 November 2009)

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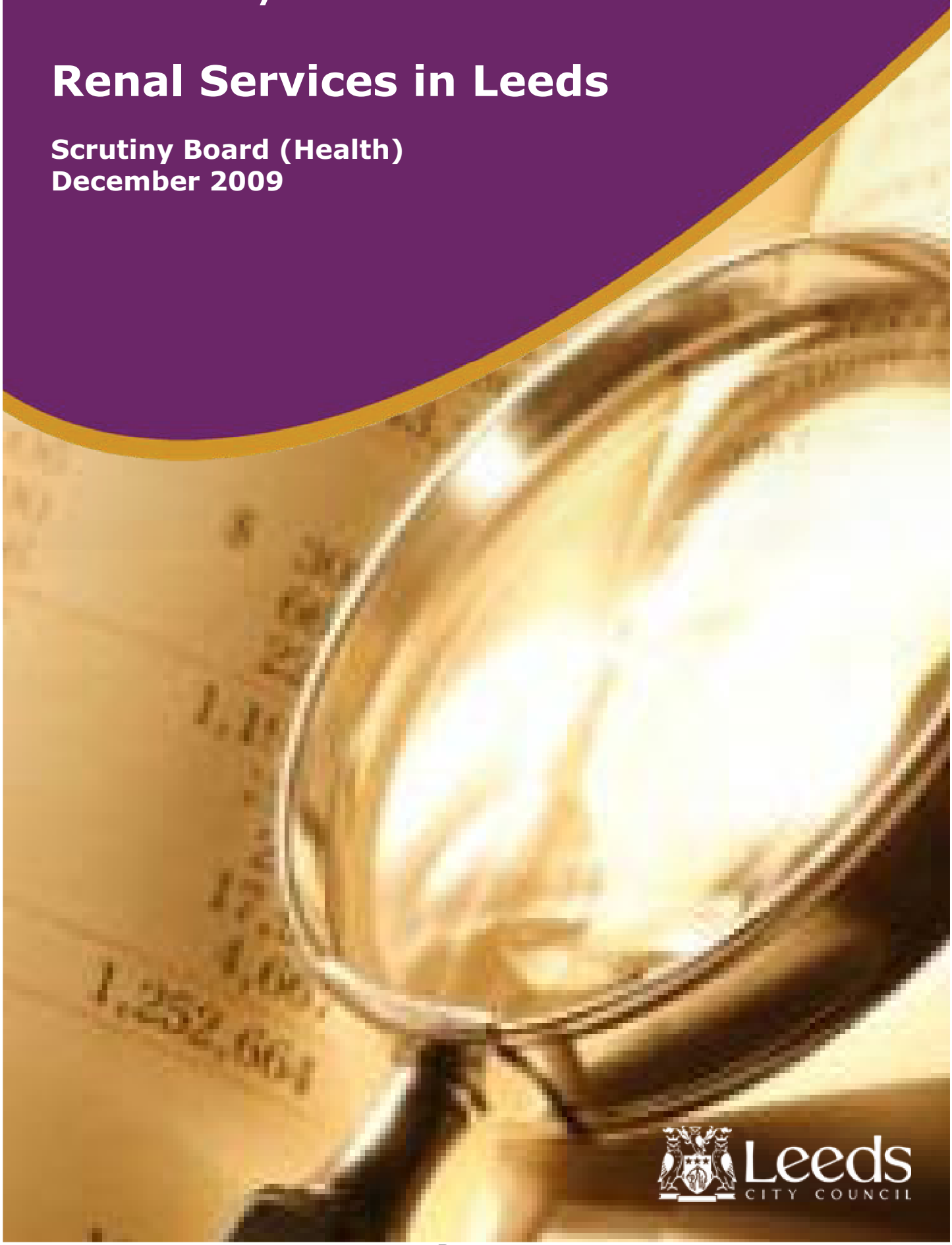
Scrutiny Statement

Renal Services in Leeds

Scrutiny Board (Health)
December 2009



Leeds CITY COUNCIL

Introduction and Scope

Introduction

1. The delivery of a 10–station renal dialysis unit at Leeds General Infirmary (LGI) has been a long awaited development for Leeds' kidney patients: It has also been a long-standing commitment of Leeds Teaching Hospitals NHS Trust (LTHT)

2. In early June 2009, the new Chair of the current Scrutiny Board (Health) first became aware of proposals not to proceed with the dialysis unit at LGI, and duly reported this to our first meeting of the new municipal year.

3. As a result, we agreed to consider the proposals in more detail at our Board meeting on 28 July 2009.

4. In order to gain a rounded view on the proposals, including the rationale and potential implications, we invited the following organisations and interested parties to provide written submissions and attend our Board meeting:

    - Leeds Teaching Hospitals NHS Trust (LTHT)
    - NHS Leeds
    - Specialised Commissioning Group – Yorkshire and the Humber (SCG)
    - Yorkshire Ambulance Service (YAS)
    - Kidney Patients Association (LGI)
    - Kidney Patients Association (St. James')

5. We also considered a written submission from the National Kidney Federation, and were provided with a summary of key dates and events, by way of a timeline (Appendix 1).

6. Following our July 2009 meeting, we rapidly drafted and agreed a position statement which was presented to the LTHT Board at its meeting on 30 July 2009. The full position statement is presented at Appendix 2, however the main conclusions can be summarised as follows:

    - Our underlying aim has always been to ensure that high quality health care services are available for all kidney patients across the City – without adding to patients' often already complicated lives.
    - We did not believe that the proposals would deliver the necessary quality for all patients.
    - We believed that the proposals represented a substantial variation to service delivery and required a statutory period of consultation.
    - We recommended that the LTHT Board defer any decision on the proposals until such consultation had taken place and, as part of any formal consultation period, there were a number of outstanding issues that we still wanted to pursue.

7. When considering our conclusions and recommendation, the LTHT Board did not agree that the proposals represented a substantial variation. However, as a result of our concerns, the LTHT Board agreed to defer its decision, pending further discussions with us.

8. The outstanding issues we wanted to pursue were confirmed by way of a set of supplementary questions, issued to LTHT and other key stakeholders on 6 August 2009.

Introduction and Scope

9. These supplementary questions covered the following broad areas:

   - Previously agreed plans
   - Strategy
   - Demand and Capacity
   - Patient Survey
   - Patient Transport
   - Role of the Scrutiny Board

10. Within the context of seeking to ensure that high quality health care services are available for all kidney patients across the City, these areas formed the scope of our further inquiry.

11. After a somewhat lengthy delay, we received the response to our supplementary questions in late October 2009 and formally considered these details at our Board meeting on 24 November 2009.

Conclusions and Recommendations

Background

12. Since issues associated with the provision of renal services in Leeds were first raised with the City Council (February 2006), it should be recognised that the terms of reference and membership of, what is now, Leeds City Council's Scrutiny Board (Health)[1], have changed on a number of occasions. This statement and its recommendations should be considered in this context.

13. Since February 2006, when the Scrutiny Board was first advised of the need to close the Wellcome Wing at Leeds General Infirmary (LGI), various matters associated with the provision of renal services have been the subject of public scrutiny on a number of occasions. This activity has tended to focus on the location and provision of haemodialysis services within the Leeds boundary.

14. As part of the decision to close the Wellcome Wing, it was agreed to reconfigure and re-house a number of services elsewhere in Leeds Teaching Hospitals NHS Trust (LTHT). This included the provision of renal dialysis.

15. In March 2006, the Scrutiny Board received an outline of the proposals to reconfigure renal services in Leeds. It was proposed that St. James' University Hospital (SJUH) would become the main centre for inpatient renal services with an expanded satellite service, delivered from Seacroft Hospital (via an 18– station dialysis unit), in addition to a new 10–station dialysis unit at the LGI.

16. At that time, the Scrutiny Board did not believe that sufficient consultation had taken place with patients around the reconfiguration proposals. On the recommendation of the Scrutiny Board, further public consultation took place between June and August 2006.

17. The outcome of the consultation and key issues agreed by NHS Leeds and LTHT were reported to the Scrutiny Board in December 2006. This included:

- Centralisation of in-patient services at St. James's
- Establishment of a permanent dialysis facility at Seacroft
- Delivery of a 10-station haemodialysis unit at LGI

18. Since December 2006, on-going issues – often associated with renal patient transport, have been reported and considered by the Scrutiny Board. In addition, there have been some changes to the proposed location of the renal unit at LGI, which have resulted in delays. However, from March 2006 until June 2009 there had never been any indication or suggestion that replacement dialysis facilities would not be provided at LGI.

[1] All references to the Scrutiny Board (Health) include all previous Leeds City Council Scrutiny Boards (since January 2006) appointed with the responsibility for the scrutiny of local NHS health care services.

Conclusions and Recommendations

Current position

19. Having received the response to our supplementary questions in late October 2009, we agreed to formally consider the additional information at our Board meeting on 24 November 2009. In order to help us consider the supplementary information in more detail, we invited the following key stakeholders to our Board meeting:

    - Leeds Teaching Hospitals NHS Trust (LTHT)
    - NHS Leeds
    - Specialised Commissioning Group – Yorkshire and the Humber (SCG)
    - Yorkshire Ambulance Service (YAS)
    - Kidney Patients Association (LGI)
    - Kidney Patients Association (St. James')

20. Unfortunately, the Kidney Patients Association (St. James') representative was unable to join our meeting, but issued a statement via the Kidney Patients Association (LGI) representative.

21. We also considered the draft Yorkshire and Humber Renal Network Strategy for Renal Services (2009-2014) which had been formally received on 16 November 2009[2].

Previously agreed plans

22. It is clear to us that the decision to deliver a renal unit at LGI formed an integral part of the agreed strategy for reconfiguring services that resulted from the necessary closure of the Wellcome Wing at LGI.

23. It is also clear that local key stakeholders, including service commissioners, LTHT, patient groups and representatives and the Scrutiny Board, were collectively involved and engaged in developing this strategy.

24. As such, we believe that all stakeholders were fully signed up to the implementation of this strategy and it is our view that all key stakeholders anticipated the timely delivery of a dialysis unit at LGI.

25. In this regard, the business case to create the dialysis unit at LGI was agreed, in its entirety, by the LTHT Board on 29 November 2007. There is also compelling evidence that LTHT repeatedly re-affirmed its commitment to deliver a dialysis unit at LGI on a number of separate occasions.

26. We are not satisfied with the rationale presented for revisiting the original decision and strongly oppose the approach adopted by LTHT, i.e. to review a fundamental element of the overall exit strategy for Wellcome Wing, both some considerable time later and in total isolation from the other elements.

27. Furthermore, within the agreed business case (November 2007), the following risks were identified:

    'By not providing this unit, there is no local dialysis for the population of west/northwest Leeds who require dialysis. Inpatients at the LGI who require dialysis will continue to be treated by a locally based renal support team, which is less cost effective, in staffing, than treating the patients from a static dialysis unit.'

[2] A copy of the draft strategy and consultation letter was received through an informal source on 9 November 2009.

Conclusions and Recommendations

28. We have not been provided with any evidence to suggest that these risks no longer exist. As such, it is our strongly held view that such risks still remain and are, at least, equally valid.

29. We feel it is important to remember that plans to re-provide dialysis facilities at LGI go as far back as February 2006. These plans were restated in March 2006 and put forward in a consultation document in May 2006. Reporting support for the proposals in December 2006, LTHT agreed a business plan for the scheme in November 2007 and reiterated its support on a number of occasions. This included confirmation of the proposals being formally reported to the Scrutiny Board in March 2008 and September 2008.

30. As such, we believe that kidney patients have waited long enough for the promised re-provision of dialysis facilities at LGI and that LTHT should cease its prevarication and deliver what has been agreed and promised.

Recommendation 1

Given paragraphs 29 and 30, Leeds Teaching Hospitals NHS Trust:

(a) Immediately re-affirms its commitment to re-provide dialysis facilities at Leeds General Infirmary; and,

(b) Finalise plans for replacement dialysis facilities at Leeds General Infirmary and deliver these as soon as practicable, but no later than December 2010.

31. Notwithstanding our opposition to the current proposal, we also believe that, given the intrinsic links with the agreed strategy for dealing with the closure of Wellcome Wing, any proposed deviation from that original decision represents a substantial variation and should be subject to a statutory period of consultation. This is in line with our previous statement attached at Appendix 2.

Strategy

32. In July 2009, we were advised that haemodialysis formed part of a wider regional strategy for renal replacement therapy (RRT), which had informed the proposal not to provide a dialysis unit at LGI.

33. We sought clarification regarding the content of this strategy and the process for its development. However from the response received we do not believe that the proposal was informed by a wider regional strategy and that, at the time of developing the proposal, no such strategy was in place.

34. Not least, this view is supported by the fact that the draft Yorkshire and Humber Renal Network Strategy for Renal Services (2009-2014) was not approved for wider consultation until 16 October 2009 and subsequently issued for consultation in November 2009.

35. Therefore, at the time that the proposal was developed, it is clear that at best the draft strategy had no formal standing, and at worst may not even have been drafted.

Conclusions and Recommendations

36. The involvement of key stakeholders, including overview and scrutiny committees across the region, should form an integral part of the development of regional commissioning arrangements and/or strategies.

37. We believe that, as the development of a regional strategy clearly represents a potential substantial development of local health services, there should have been some very early dialogue between SCG and overview and scrutiny committees.

38. This dialogue should have included an indication of the potential implications and also the role of scrutiny in the development of the strategy. There is no evidence of any such dialogue.

39. However from the evidence presented to we can find no indication of any engagement with any health overview and scrutiny committees across the region in this regard.

40. While we have received statements of intent from SCG around involving and engaging overview and scrutiny committees across the region (via extracts from the strategy – *'Involving and Engaging Patients and the Public in Specialised Commissioning'*) and also received some evidence where such engagement had taken place on a regional basis[3], we believe the arrangements associated with the development of the regional renal strategy highlight some significant failings an inconsistencies within SCG.

Recommendation 2

By May 2010, the Yorkshire and the Humber Specialised Commissioning Group review its current work programme to identify those areas of service development where overview and scrutiny committees should be actively engaged, and propose an appropriate timetable of activity.

41. Following the original decision to deliver a 10-station dialysis unit at LGI, we asked service commissioners and LTHT to explain what had subsequently changed and why a unit at the LGI was no longer needed.

42. We were advised that the proposal had only come about as LTHT had further carefully scrutinised clinical need, capacity and cost. However, LTHT also advised us that '*There remains no clinical need for such a facility at LGI*.' and that it was due to, *'…a considerable amount of concern expressed from users… that the Trust proposed the 10 station unit [at LGI]* – indicating that the original decision was never based on clinical need.

43. We strongly believe that if the proposal had been informed by changing clinical need, this would have been driven by the service commissioners rather than LTHT, as the service provider. However, as we were advised that service commissioners were not aware of LTHTs proposals until after 2nd June 2009, this is clearly not the case.

[3] In relation to the national and regional plans for the reconfiguration of Specialised Burn Care Services

Conclusions and Recommendations

44. We raised the issue of communication failure between the service commissioners and LTHT, which to a large degree was rebuffed. However, despite the view expressed by LTHT, we believe this episode demonstrates a serious breakdown in communication. This is further evidenced by the update provided to the NHS Leeds Board in February 2009, where it was reported that::

    'The longer term agreed plan for these stations is to maintain 18 stations at Seacroft and to relocate 10 stations to a renovated area within LGI.'

45. In November 2009, NHS Leeds acknowledged that there had been communication difficulties between service commissioners and LTHT, and went on to advise that new procedures would be put in place to ensure communication was improved. However, details of the necessary improvements and how these would be implemented were not provided.

Water treatment plant – SJUH

46. We have also received conflicting information regarding the significance of the replacement of the water treatment plant at SJUH and the impact this had on the proposed unit at LGI.

47. In July 2009, we were advised that the need to replace the water treatment plant at SJUH was a higher priority than to provide the additional unit at LGI – the result of which was a substitution within the Capital Programme.

48. However, in November 2009 we were advised that the two schemes were not linked and the proposal around the LGI scheme was not based on an 'either / or' position or discussion.

49. Notwithstanding the contradictory information provided at public meetings, we have written communication (dated 26 May 2009) from LTHT's Director of Planning which comments on this situation, as follows:

    'In effect, we have substituted one renal priority for another. Many more renal patients will be affected if we don't sort the water treatment plant than if we don't sort the LGI dialysis unit.'

50. In the communication, the Director of Planning also stated:

    'If we had enough capital to meet all the 9/10 requirements we would still be proposing to deliver the dialysis unit at LGI.'

51. We feel that LTHT has knowingly presented us with misleading information and believe that the proposal not to proceed with the dialysis unit at the LGI was based on an 'either/ or' type discussion. Indeed, in a report to the LTHT Board in July 2009, the clinical views on the water treatment plant at SJUH and the proposed unit at LGI were presented side-by-side. For LTHT to state that discussions and decisions about both schemes are not linked seems very disingenuous.

52. Furthermore, we feel this provides clear evidence that the proposal was based solely on financial considerations, with other factors, such as clinical need and patient safety issues, being secondary and convenient considerations.

53. We also believe that to have an 'either / or' type discussion regarding an agreed capital programme scheme and a item of planned maintenance is inappropriate and demonstrates some serious weaknesses in the financial planning processes in LTHT.

Conclusions and Recommendations

Capacity

54. In September 2008, we had been advised that work on a new 24–station dialysis unit at Seacroft Hospital had commenced in May 2008, with work on the 10–station unit at LGI due to start shortly.

55. However, as recently as February 2009, it was reported to the NHS Leeds Board that::

    'The longer term agreed plan for these stations is to maintain 18 stations at Seacroft and to relocate 10 stations to a renovated area within LGI. The new unit will open on Ward 44 at Leeds General Infirmary in December 2009. As of October 2008 LTHT report that discussions were ongoing with patient representatives regarding the roll out of this development.'

56. This confirms that, while the provision of a 10-station unit at LGI had been a clear part of the plans for renal services for some time, the precise number of stations to be provided at Seacroft has been less clear.

57. Nonetheless, in July 2009 we were extremely shocked to hear that the permanent Seacroft unit was established with 34-stations – almost a 100% increase on the 18 stations expected by NHS Leeds.

58. Having queried the actual number of stations provided at Seacroft, in November 2009 we were advised of a process involving SCG and LTHT which resulted in an increase in capacity at Seacroft being agreed, to help service West Yorkshire.

59. However, this change in capacity occurred without our knowledge or involvement and, based on their report in February 2009, that of NHS Leeds: Yet, this increase in capacity at Seacroft was then used as part of the justification for not proceeding with the planned unit at LGI.

60. In November 2009, LTHT also reported that:

    '…there was never any suggestion that having more stations than at first identified was going to be a problem.'

    'The Trust would not normally advise the Scrutiny Board when it was creating additional capacity.'

61. Department of Health (DH) guidance states NHS Trusts should discuss any proposals for service change at an early stage, in order to agree whether or not the proposal is considered substantial.

62. It is our understanding that the DH guidance is provided in the context of all services changes and/or developments and is not limited to reductions in service or capacity.

63. Furthermore, it is clear that the originally agreed provision of dialysis stations at Seacroft and LGI (as replacement of the facilities previously provided in the Wellcome Wing) are inextricably linked and, therefore, any change in capacity in either of those locations could have longer-term implications in terms of the sustainability of other facilities.

64. As such, we find it incredible that LTHT failed to recognise the importance of discussing any proposed changes around capacity at Seacroft, including the associated rationale, with us before they were agreed and implemented.

Conclusions and Recommendations

65. We would have welcomed the opportunity to have examined any implications of proposed changes at the time of the original discussions, and it is extremely regrettable and deeply concerning that we were not afforded this opportunity.

66. We feel that this demonstrates a lack of awareness in terms of LTHT's statutory duty to engage and inform us about proposed changes and/or developments of local health care services. It is also our view that, at best, this demonstrates very poor judgement on behalf of LTHT and, at worst, contempt for our role as the public watchdog for local health care services.

67. We would also question whether there has been a deliberate attempt to build up capacity at Seacroft, in order to make the proposed unit at LGI unsustainable and unnecessary.

Demand

68. In July 2009, we were repeatedly advised that it was the shared view of the service commissioners (i.e. SCG, and NHS Leeds) that the current arrangements were sufficient to deliver the necessary capacity in the immediate, medium and longer-term. As such, LTHT's proposal not to invest in the re-provision renal dialysis facilities at the LGI would be the right decision.

69. However, we were also advised by the National Kidney Federation that numbers of patients requiring all forms of renal replacement therapy are anticipated to grow for the foreseeable future, with the greatest demand coming in the hospital based haemodialysis sector, (forecast to rise by up to 8% per annum).

70. Furthermore, in November 2009 we were advised that it was 2 years since any detailed modelling work had been undertaken on the likely future numbers of end stage renal failure patients across Yorkshire and the Humber. We were also advised that further work was needed to develop confidence in the new modelling tool being used to help predict future patient numbers. This position is supported by the action plan detailed in the draft Yorkshire and Humber Renal Network Strategy for Renal Services (2009-2014).

71. Again, it appears that we have been provided with, at best, conflicting and, at worst, misleading information in terms of future demand. As a result, we have no confidence in the position reported to us in July 2009 and believe that further modelling work is needed to understand the likely demands for renal dialysis both within the Leeds boundary and across the region.

72. We feel that the arguments put forward regarding both capacity and demand fail to stack up and the original information provided in July 2009 has failed to stand up to further scrutiny.

73. We believe that information has been manipulated to support the notion and management position that a dialysis unit at LGI is not required.

Patient Survey

74. In July 2009, service commissioners and LTHT made significant reference to the outcome of a patient survey: They reported to us that, in a survey of patients receiving treatment at Seacroft, only 11 patients (from a total of over 85) had indicated a desire to relocate and receive their treatment at LGI. Indeed,

the service commissioners used this evidence to support the argument that to proceed with the planned unit would represent *'very poor value for money'*.

75. Details relating to the outcome of the patient survey were also presented and reported to the LTHT Board in July 2009, where it was stated:

'There are approximately 490 patients currently on dialysis, 11 have said they would prefer to go to the LGI. '

76. In our follow-up questions, we asked for more information on how the survey was undertaken and a full summary of the results. From the additional information received, it became patently obvious that the survey methodology was severely flawed – as the survey was intended for a different group of dialysis patients and sent to Seacroft patients in error.

77. We reached the conclusion that the patient survey data presented was wholly inappropriate and clearly invalid. When pressed, LTHT finally agreed to withdraw the patient survey data – also stating this would not be used in any further reports to the LTHT Board.

78. However, this leads us to question the robustness of internal mechanisms and quality assurance processes within LTHT and service commissioners. Current systems and processes have allowed flawed and misleading information to be presented to us and the LTHT Board itself. This information has been presented 'as fact', when it is quite clearly not fit for purpose.

79. We believe this further demonstrates the manipulative approach taken when presenting information to us, and possibly the LTHT Board itself – in an attempt to construct an argument in support of, and justification for, a proposed u-turn on an agreed service development. Our level of deep concern in this regard cannot be overstated.

Patient Transport

80. Since early 2006, when the initial proposals to close the Wellcome Wing and relocate renal services elsewhere were first raised, issues associated with patient transport have transcended many of our discussions around renal services.

81. On a number of occasions we have focused on the provision and reliability of transport services for kidney patients: We have heard of the plight of many patients, including the sometimes tortuous journey times endured, in order to access the thrice-weekly life-saving treatment they need.

82. However, consideration of such matters has always been in the knowledge and firm belief that, in the longer-term, some of the difficulties around patient transport would be resolved by the re-provision of dialysis facilities at LGI.

83. Initial comments from the Yorkshire Ambulance Service (YAS) reaffirmed this to be the case for some patients – particularly those accessing services from the North and North–West of the City. However, in order to gain an insight into the wider patient transport perspective, we sought additional data for the West Yorkshire sub-region.

84. In November 2009, we were presented with a range of patient transport data (provided by YAS), including the journey times of dialysis patients travelling from specific Leeds postcode areas.

Conclusions and Recommendations

85. On reviewing the additional information, it quickly became apparent that once again we had been presented with inaccurate information that was wholly inappropriate and not fit for purpose.

86. The information was so completely inaccurate, it was embarrassing that this had been submitted as 'fact' within a public arena. We feel this demonstrates a distinct lack of local knowledge across each of the NHS organisations that had been party to information prior to its formal submission.

87. The level of inaccuracy quickly led to YAS seeking to withdraw the information from the meeting and making a firm commitment to investigate the circumstances which had led to the information being presented to us in such a way.

88. We believe this is further evidence that the quality of information provided to us by a range of NHS bodies has been extremely poor and totally unacceptable.

89. This has given rise to us questioning the accuracy of other transport data presented, both at the meeting in November 2009 and historically.

90. We would also question the role that such data may have had in the performance managements arrangements between LTHT, YAS and other service commissioners in any other broader ambulatory and transport arrangements. We call for an immediate review of such arrangements and supporting processes.

Recommendation 3

Following the circumstances and processes associated with the proposal not to re-provide dialysis facilities at Leeds General Infirmary, as highlighted in this report, that by June 2010, the Secretary of State for Health commissions and publishes an independent review that:

(a) Focuses on the lessons learned and areas for improvement, which presents an appropriate action plan;

(b) Reviews the financial planning processes and financial management arrangements of Leeds Teaching Hospitals NHS Trust;

(c) Considers the circumstances which resulted in an increase in renal dialysis capacity at Seacroft Hospital, without the engagement of the Scrutiny Board (Health) and, seemingly, NHS Leeds;

(d) Considers any manipulation of key information (e.g. patient survey information) which has been presented as justification for the proposals;

(e) Considers arrangements for the production and use of patient transport data in the performance managements arrangements between all local NHS organisations, as appropriate.

Conclusions and Recommendations

Draft Renal Strategy (2009-2014).

91. As previously outlined, as part of our deliberations in November 2009, we considered the draft Yorkshire and Humber Renal Network Strategy for Renal Services (2009-2014) – which had been distributed to key stakeholders across the region, seeking comments by 31 December 2009.

92. With regard to this consultation period, we believe the timescales to be wholly inappropriate – leaving local overview and scrutiny committees barely six weeks in which to provide a response.

93. To put this view into context, it should be recognised that:

- For most, if not all committees, we believe the draft strategy will have appeared unexpectedly;
- Most committees are likely to be already working to an agreed work programme and would need an opportunity to consider the merits of rescheduling any planned items;
- The consultation period includes Christmas – which in reality shortens the consultation period further.

94. Until receiving a copy of the draft strategy we were unaware that this was under development. As of July 2009 we believed that this strategy was already in place and being used to inform the development of local services. We now believe that this was not the case.

95. In August 2009, we asked how overview and scrutiny committees (from across the Yorkshire and Humber region) had been involved in the development of the strategy, but have not been provided with any evidence to suggest any involvement of local overview and scrutiny committees in this regard.

96. Nonetheless, in November 2009 we were advised of SCG's strategy for involving and engaging patients and the public in specialised commissioning, which included the following objective:

'Develop an on-going positive relationship with Overview and Scrutiny Committees in Yorkshire & the Humber, both individually and through the Yorkshire & the Humber Health Scrutiny Network.'

97. While it is clear that the meaningful involvement and engagement with local overview and scrutiny committees has, at best, been limited, we would also question SCG's capacity to provide a consistent and necessary level of support to individual overview and scrutiny committees across the region, during the consultation period.

98. We have not had a detailed discussion about the local implications of the draft strategy, however we would initially offer the following observations:

- There is no reference to this being a new or updated strategy;
- Information on the approximate number of people living in Yorkshire and the Humber is not consistent with other details presented to us and is 0.3 million lower;
- The total number of haemodialysis patients presented in Figure 2 and 3 do not correspond;
- References to the projected increase in demand and the need for significant capital investment do not appear to be consistent with the details presented to us by service commissioners and LTHT.

Conclusions and Recommendations

- We note that an early task within the draft strategy is to undertake a review of capacity. Again, this does not appear to be consistent with some of the details presented to us by service commissioners and LTHT.
- The proposed work plan included in the draft strategy provides no indication of the significance or priority of various actions. Neither does the work plan provide details of key dates or timescales for the various actions. In order to ensure that the strategy is performance managed and reviewed on an annual basis (as indicated), it is essential that these elements are included.

Recommendation 4

Prior to finalising the draft Yorkshire and Humber Renal Network Strategy for Renal Services (2009-2014), the Yorkshire and the Humber Specialised Commissioning Group review current consultation arrangements and, through dialogue with overview and scrutiny committees across the region, develop an extensive 12-week consultation plan.

Role of the Scrutiny Board

99. For some considerable time, we believe that LTHT's preferred location for renal dialysis has been Seacroft Hospital and that a dialysis unit at LGI is not a 'strategic fit' in terms of other plans across the Trust – in particular those associated with the clinical services reconfiguration (CSR).

100. Since July 2009, we believe service commissioners and LTHT have been seeking evidence to justify the proposal not to re-provide dialysis facilities at LGI and have been actively trying to construct a business case in support of the proposal.

101. We believe there is sufficient evidence to demonstrate that LTHT initially developed the proposal in complete isolation, without reference to other key stakeholders, including service commissioners, the Scrutiny Board and, most importantly, the patients and carers directly affected.

102. Furthermore, we believe that LTHT made no reference to other strategies or frameworks that should inform the development of renal service provision and the proposal was based purely on a financial decision to help achieve equilibrium on the balance sheet.

103. We believe this is, in part, demonstrated by the extraordinary length of time taken to respond to our request for additional information. In our opinion, if the proposal had been evidence based, the additional information would have been readily available and provided in a much shorter timescale. This was clearly not the case.

104. We also believe that much of the evidence presented to us has been subject to bias and manipulation, and has therefore been found wanting in terms of its accuracy and appropriateness. Therefore, we conclude that there is no case in support of the proposal not to re-provide dialysis facilities at LGI.

Conclusions and Recommendations

105. Furthermore, we have already commented on how, as a Scrutiny Board, at times we believe we have been regarded as an irrelevance and therefore conclude that further work is now needed to repair and strengthen our relationship with local NHS organisations – be they commissioners or providers of locally, regionally or nationally based services.

Recommendation 5

In light of the issues identified and highlighted by this inquiry a review of the locally agreed protocol between the Scrutiny Board (Health) and NHS Bodies in Leeds be undertaken by June 2010.

Foundation Trust Status

106. In November 2009, we also heard about LTHT's proposals and associated processes for achieving Foundation Trust (FT) status.

107. We considered the FT proposals in detail and hope to provide a separate consultation response in due course. However, there are some aspects of the FT proposals and consultation document which, in our view, are very pertinent to the issues and circumstances associated with renal services.

108. The consultation document is entitled 'Your hospitals, Your say' and it is interspersed with references about the benefits of being a Foundation Trust, such as:

- *'greater freedom to develop services'*
- '*more accountable to the local community'*
- *'able to tailor local services to the needs of local people'*

109. The consultation document also details a number of commitments that LTHT would sign up to as a Foundation Trust, including:

- *asking the views of members*
- *tailoring services*
- *supporting patient choice*
- *involving local communities*
- *working more closely with other bodies*
- *strengthening contractual arrangements with other organisations*

110. However, based on our recent experiences and the evidence identified in this statement, we believe that at the present time, these fine words are just that – fine words.

111. We would all support these statements of intent, and agree that greater involvement of local communities in shaping local health services is a positive step forward. Nonetheless, at this moment in time, we do not believe there is sufficient evidence to demonstrate that LTHT have the necessary organisational competencies or track record to deliver such commitments. As such, we have grave reservations in supporting LTHT's application for FT status.

112. LTHT has an annual budget approaching £800 million and we firmly believe that the public of Leeds and the surrounding areas deserve to be reassured about the management and organisation of LTHT – including key business processes. We believe that such reassurance needs to be provided prior to any further devolvement of power and increased autonomy.

Conclusions and Recommendations

Recommendation 6

That NHS Leeds, NHS Yorkshire and the Humber and the Secretary of State for Health seriously consider the content of this report, its recommendations and any subsequent responses, prior to supporting any current or future Foundation Trust application from Leeds Teaching Hospitals NHS Foundation Trust.

Recommendation 7

That this report be issued to the Secretary of State for Health seeking the appropriate action be taken to secure the immediate implementation of Recommendation 1.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
FEB. 2006		2 Feb. 2006 **Wellcome Wing at LGI** The Board was briefed on the main themes of the business case concerning the future of Wellcome Wing. The following points were made: • The Wing housed several different services, including the Renal Service. • Its structure dated from the early 1960s and the electrical infrastructure was in need of major remedial work • There were serious concerns about the presence of asbestos in the building. • Refurbishment costs of between £9m and £17m were anticipated. • A timescale of around two years was likely for the necessary work. **RESOLVED** The Board endorsed the recommendation that **Option 6** should be progressed, noting that further business cases would be received in due course for each element of the re-provision of services within Wellcome Wing.	13 Feb. 2006 The Board was advised that LTHT had approved in principle the vacation and closure of the Welcome Wing at the LGI, with all services based there, including renal services, being reconfigured and rehoused elsewhere in the Trust. Members were advised that the Trust believed that the best option for the disposition of renal services was to centralise inpatient beds and acute dialysis on the St James's site and to provide satellite dialysis units on the LGI and Seacroft Hospital sites The Board requested that further information on the proposed transfer be submitted to the March meeting of the Scrutiny Board	**Option 6 included:** • Ward 32 (inpatients) would be reprovided into Lincoln Wing at St James adjacent to the current renal wards. (**Capital cost £1.745m** for the new ward.) • 18 dialysis stations would be created at Seacroft hospital with all supporting facilities. (**Capital cost £1.697m** for the Seacroft dialysis station.) • ***A 10 dialysis station unit would be created at LGI***. **(Capital cost £0.5m** for the 10 station dialysis unit at LGI.) • Outpatient facilities at LGI would remain as would vascular access and on site renal support to LGI patients.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
MAR. 2006			13 Mar. 2006 **Proposals on the Reconfiguration of Renal Services in Leeds** The Board received an outlined of the proposals to reconfigure Renal Services in Leeds. It was reported to the Board that the proposals to close the Wellcome Wing at the LGI would include an expanded satellite service, which would be delivered from Seacroft Hospital, ***in addition to a new 10 bed unit at the LGI for patients with chronic renal failure***. **RESOLVED** (i) That the Chair writes to the Chief Executive of Leeds Teaching Hospitals NHS Trust to convey the views of the Board and recommend that further consultation is carried out with patients on the reconfiguration proposals in an open and transparent manner. (ii) That the Trust is asked to provide a written response to the Board's recommendation prior to the Board's meeting in April 2006.	The Board heard from a range of stakeholders, including: • Leeds Teaching Hospitals NHS Trust • The LGI Kidney Patients Association's • UNISON reps. from LTHT • RCN reps. Members raised concerns that patients had not been reassured at any time throughout the process, and acknowledged that although consultation had occurred in 2000, on the whole the consultation process had been unsatisfactory.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
APR. 2006		6 Apr. 2006 **Matter arising: Wellcome Wing** The Board was informed that the Council's Scrutiny Board had recommended a period of public consultation with regard to the Trust's proposals to relocate Wellcome Wing. It was explained that the PCTs would lead this process. The Board accepted the Scrutiny Board's recommendation.	10 Apr. 2006 **Matters arising** It was reported that a formal response had been received from LTHT in relation to the Board's recommendation for further consultation and it was confirmed this had been approved at the Trust Board meeting held on 6th April 2006. ***Members were assured that the Board would be informed of any developments as they occurred***.	
JUN. 2006		1 Jun. 2006 **Wellcome Wing Contingency Plan** The Board received an update on the Wellcome Wing Contingency Plan. The Board was briefed on the need for urgency and the action being taken to communicate with external stakeholders and to identify temporary accommodation for the services that would need to move. It was agreed that any urgent action that became necessary would be pursued by way of Chairman's Action as opposed to extra-ordinary Board meetings.	19 Jun. 2006 **Presentation from Local Primary Care Trusts and Acute Trusts** Under a general item, it was reported that consultation on the reconfiguration of renal services had commenced and would be completed in August 2006. The Board agreed to continue to keep a watching brief on this matter.	

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
JUL. 2006		6 Jul. 2006 **Wellcome Wing Exit Programme** The Board noted the progress towards vacating Wellcome Wing by the end of October 2006. The Board was reminded that the arrangements were temporary and could need to change as a result of the consultation process currently in progress.		
AUG. 2006		3 Aug. 2006 **Interim Re-provision of Renal Services from Wellcome Wing** The Board was presented with an interim solution for the reprovision of renal services, which highlighted the need for urgency as part of the process of vacating Wellcome Wing. The Board was advised that the consultation process concerning the future of renal services continued and was unaffected by the proposal. The business case received the Board's approval.		

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
SEP. 2006			18 Sep. 2006 **Consultation Update: Reconfiguration of Renal Services in Leeds** The Board received a verbal update on the consultation process from LTHT and advised that the analysis was due to be submitted to the LTHT Board in October 2006. Members urged the Trust to maximise transportation links for patients and requested further details about the re-provision of renal services and the evaluation of the consultation process as soon as was practicable. **RESOLVED –** (i) That the information detailed within the report be noted; (ii) That the Airedale consultation document be circulated to Members for their information; (iii) That an update on the information relating to the re-provision of renal services in Leeds in addition to the evaluation of the results from the consultation process be circulated to the Board as soon as is practicable; (iv) That a letter on behalf of the Board be forwarded to the Chief Executive of Leeds Teaching Hospitals NHS Trust which outlines the Board's comments about need to maximise transportation links for patients.	At the Scrutiny Board meeting, the LGI Kidney Patients Association, raised concerns over the way in which the whole consultation process had been conducted.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
OCT. 2006		5 Oct. 2006 **Update on Wellcome Wing Exit Programme** The Board was reminded of the exit programme and contingency plans associated with the closure of Wellcome Wing. ***It was confirmed that the Trust would be able to re-provide all of the services previously housed there.*** **Renal Services Consultation** The Board received the summarised outcome of the formal consultation, however a formal recommendation was awaited from the newly-formed Leeds PCT, which had now assumed responsibility for the process The Board accepted the outcome of the consultation process and, subject to the PCT's recommendation, confirmed its support for the proposals being taken forward as set out in the consultation document. The Board also agreed that the Trust should pursue the concerns raised during the consultation process.	23 Oct. 2006 **Reconfiguration of Renal Services in Leeds** The Board received the Consultation Analysis document presented to the LTHT Board on 5 October 2006. **RESOLVED –** (i) That the report be noted. (ii) That further consideration be given to the Reconfiguration of Renal Services in Leeds following consideration of the consultation analysis by the Leeds Primary Care Trust.	**PROPOSALS** (as presented in the consultation document) • Create a new haemodialysis unit at Seacroft Hospital • Centralise the renal inpatient bed base at St James's • Centralise the peritoneal service at St James's • ***Create a 10 station dialysis unit at LGI as the local facility for dialysis patients in the West and Northwest of the city and for inpatients at the LGI suffering acute renal failure***. The written consultation process received 297 responses. The analysis of responses showed: • 53% (156) supported the proposal • 21% (61) opposed the proposal • 26% (80) were neutral

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
NOV. 2006	16 Nov. 2006 **Renal Services Consultation** The Board received the summarised outcome of the formal consultation and resolved to: (i) Note the findings of the consultation analysis; (ii) Support the Trust in working with partner organisations to address the specific concerns raised in the consultation; (iii) Strongly recommend that LTHT pursue a solution for dialysis patients from the west of the city in the short term and have discussions on a satellite unit at WGH; (iv) Consider pursuing alternative provision should an acceptable resolution not be reached to recommendation (iii) above.		20 Nov. 2006 **Matters arising** It was reported that a further report on the Reconfiguration of Renal Services in Leeds at the December Board meeting.	There was broad agreement between LTHT and Leeds PCT on the substantive issues arising from consultation and about the way forward. A number of key issues were identified and both organisations met to agree the next steps in key areas. These are set out in the attached document.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
DEC. 2006			18 Dec. 2006 **Reconfiguration of Renal Services in Leeds** The Board considered a joint report from Leeds PCT and Leeds Teaching Hospitals NHS Trust (LTHT) following the renal services consultation. Issues discussed included: • Timescales associated with the provision of a 10-bed unit at the LGI for patients with chronic renal failure. • Using Wharfedale Hospital to provide a satellite unit to serve those in the North West of the City. • Transport issues. **RESOLVED –** a) That the report be noted. b) That a further report be brought to the Board which specifically addressed the transport issues raised by renal patients.	At the Scrutiny Board meeting, the LGI Kidney Patients Association expressed concern regarding the consultation process and felt that it was flawed. Amongst concerns raised was that the consultation literature was not translated for ethnic groups which will have resulted in a lack of responses. It was also felt that the consultation process should have been carried out by an independent body rather than the PCT as the commissioning body. Further issues of concern included transport provision, access to Seacroft Hospital and the affect on the quality of life for patients.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
JAN. 2007			22 Jan. 2007 **Reconfiguration of Renal Services in Leeds - Patient Transport Issues** The Board considered current transport provision, alongside additional information on the tendering process for transport. **RESOLVED** a) That the report be noted. b) That the Board receives a further report in March 2007 on the wider issues relating to the reconfiguration of renal services in Leeds.	It was reported that the tendering exercise was currently being evaluated and the results could be made available to the Board in due course. Following the last meeting of the Board where it was suggested that a member of the Kidney Patients Association participate in the tendering process, it was reported that this had happened successfully
APR. 2007			23 Apr. 2007 **Provision of Renal Services in Leeds** The Board was informed that that only one viable bid had been received for the transport tender, however it was anticipated that the new arrangements would include a number of measures to strengthen transport provision, including stricter penalties and the provision of a dedicated transport contact desk within the Yorkshire Ambulance Service. **RESOLVED** That the report be noted	The Board was advised that proposals for the establishment of a permanent facility at Seacroft Hospital and ***a 10 station satellite unit at Leeds General Infirmary (LGI)*** were to be considered by the LTHT Management Board. Planned dates for completion of the new facilities were Autumn 2008 for Seacroft and ***June/July 2008 for LGI.***

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
NOV. 2007		29 Nov. 2007 **Business Case for creating a permanent renal haemodialysis unit at Seacroft Hospital** **Business Case for creating a renal haemodialysis unit at Leeds General Infirmary** The LTHT Board considered the two business cases in consequence of the closure of Wellcome Wing. The Board was reminded that both units had been agreed as part of the Wellcome Wing emergency closure process and ***honoured commitments made to the KPA at an earlier Board meeting.*** The Board was advised that the precise location of the Unit had been discussed with the KPA and other users and Ward 46 was their preferred location. **Both business cases received the Board's support.**		14 Nov. 2007 Letter from the Chair of the Scrutiny Board to LTHT *seeking clarification on timescales and location of the 10 station unit at LGI* and concerns raised by the KPA. 29 Nov. 2007 It was reported to the LTHT Board that £3M had been allocated in the capital programme across 07/08 and 08/09 for renal dialysis schemes and that the LGI scheme: • Fits the overall direction of the Trust in demonstrating its responsiveness to patient demand for an accessible dialysis service on the LGI site; • Was estimated to cost £1.7m but would not incur additional revenue expenditure; • Would deliver dialysis to inpatients at the LGI with acute renal failure and chronic renal patients receiving inpatient care in another specialty at the LGI.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
MAR. 2008			17 Mar. 2008 **Matters arising** The Board considered an update on the long-term plans for Renal Services in Leeds. This included plans to provide ***a 10 station satellite unit at Leeds General Infirmary (LGI).*** It was reported that: • The new unit was planned to be sited in Ward 46 • Works would go out for tender on 25 April 2008 • It was expected that LTHT Board would agree the approved contractor on 26 June 2008, with a start on site date of 14 July 2008. • The works were anticipated to be completed on 12 December 2008, with commissioning taking place between December 2008 and January 2009. **RESOLVED** a) That the report be noted. b) That WYMAS be contacted and requested to supply the Board with information regarding the transport of patients accessing Renal Services.	The KPA advised the Scrutiny Board that they still had some concerns, including: • Facilities at Seacroft Hospital breaking down. • Demand for services at St James and the ability to meet this demand. • Transport – although the KPA had been actively involved in the tendering process, only one suitable bid had been received. Problems had been encountered with the transport of patients and examples of patients not being collected for treatment and the adverse knock on effects were given. • ***The timescale to implement new provision at Leeds General Infirmary***

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
JUN. 2008			**Work Programme** As part of the new Board's discussions around its work programme, Members were advised that the Scrutiny Board received regular reports regarding the long term plans for renal services in Leeds. Following a monitoring session held on 17 March 2008, it was highlighted that the Leeds Kidney Patients Associations (LGI and SJUH) had concerns regarding the transport provided by Yorkshire Ambulance Service (YAS) under contract to LTHT. **RESOLVED** a) To include renal services (particularly around transport) as part of the Board's work programme.	LTHT, YAS and KPA invited to attend the Board in September 2008 to update Members, particularly in terms of any on-going renal transport issues.
JUL. 2008		**Award of Contract - Renal Dialysis Unit at the Leeds General Infirmary** Considered as part of the non-public part of the agenda. (No public minutes available)		

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
SEP. 2008			16 Sep. 2008 **Renal Services** The Board heard from NHS Leeds, LTHT, YAS and the KPA. The main issues centred around the operation of the renal services transport contract between LTHT and YAS. The KPA provided examples of problems experienced transporting patients to and from appointments, including late and missed collections of patients and patients having to travel on long unnecessary journeys whilst other patients were collected. The Board was reminded that during discussion around the reconfiguration of Renal services, the KPA had highlighted a number of areas of concern, particularly in terms of transport arrangements. **RESOLVED** That the report and information presented be noted. That a further report be presented to the Board, to include greater detail on current performance and trends in performance, particularly in the areas discussed at the meeting.	Following closure of Wellcome Wing, the report presented to the Board confirmed the following service changes: • **February 2008**: Inpatient ward moved to ward 62 in Lincoln Wing at St James's in. • **May 2008**: Work started on 24-station unit at Seacroft Hospital. Completion: Jan. 2009. • Work due to start shortly at LGI to create a 10-station chronic unit, with 2 acute beds. Completion: Spring 2009. LTHT and NHS Leeds stated their intention to continue to work in partnership with both the YAS and the Kidney Patients Association (KPA) in an attempt to resolve areas of concern.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
OCT. 2008		23 Oct. 2008 **Briefing note on renal dialysis services at LTHT issued to the Chair of the Scrutiny Board** • Confirmed the new renal dialysis satellite unit would open on Ward 44 in December 2009. • Described the delay as a result of the Children's Hospital Services Reconfiguration. • Confirmed the unit will meet the commitment made by the Trust to re-provide renal dialysis facilities at LGI • Outlined that a new 6-station (previously stated as a 10-station) unit, costing over £1m would provide services for patients who prefer to dialyse in the City Centre.	21 Oct. 2008 **Renal Services – Transport Update** The Board considered a report from YAS, which detailed statistical information in relation to transport provision. This also included benchmarking information against the Cheshire and Merseyside Action Learning Set. The Board was also informed of 3 main areas highlighted at the recent meeting between the YAS, LTHT and KPA which focussed on planning concerns, communication issues and how to reduce complaints. Reasons for missed appointments were also highlighted. **RESOLVED** That the report be noted and the Board be kept updated on the position regarding Renal Services transport.	At the Scrutiny Board meeting the KPA informed Members of outstanding concerns which included: • Responses to complaints; • Times involved in transporting patients; and, • The future provision of services at Leeds General Infirmary

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	

FEB. 2009	6 Feb. 2009
	Renal Services update report presented to the Trust Board. The report stated:
	• No formal targets for delivery of renal services – but standards and markers for good practice.
	• Sufficient capacity within the city to provide dialysis to all patients who require it.
	• ***The longer term agreed plan was to:***
	  ○ ***Provide 18 stations at Seacroft***
	  ○ ***Relocate 10 stations at LGI (due to open in Dec. 2009)***
	• Main, continuing issue for patients revolves around transport availability and response to individual needs.
			6 Feb. 2009
			Letters to LTHT and YAS on behalf of the Scrutiny Board regarding the concerns of the Scrutiny Board regarding the ongoing problems associated with renal patient transport – particularly in relation to a '*number of quite severe difficulties'* over the Christmas period, highlighted by the KPA.
			26 Feb. 2009
			Response from LTHT (to letter dated 6 February 2009) and advised the following:
			• Every effort being made to improve the renal patient experience in respect of transport and a Renal Patient Transport Steering Group had recently been established
			• Over the Christmas period, Renal Units closed on different days of the week and inconsistent information was given YAS.
			• For future Christmas periods, there will be a standard approach from all the Renal Units over communications with YAS
			• Other work being undertaken around:
			  ○ Patient journey experience
			  ○ Patient transport – eligibility criteria
			  ○ Patient awareness, including patient responsibilities around transport
			  ○ Communication to improve aborted inward journeys
				In January 2009, the KPA highlighted concern over ongoing renal patient transport difficulties, with particular with specific reference to problems over the recent Christmas period.
				Concern was also expressed regarding the delay to and the long-term plans for the LGI renal unit.
				6 Feb. 2009
				Letter sent to KPA advising of the approach to seek information from LTHT and YAS.

Appendix 1

TIMELINE SUMMARY

MONTH	ACTIVITY:			NOTES
	NHS LEEDS	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)	
MAR. 2009			10 Mar. 2009 Response from YAS (to letter dated 6 February 2009) providing details of the service review undertaken (covering the Christmas period). YAS recognised that some patients experienced a disrupted service with their transport over the Christmas holiday period. Some of the outcomes of the review included: • No Patient failed to be transported as a result of YAS failings. • 54 patients (w/c 22/12/08) and 29 patients (w/c 29/12/08 experienced delays as a result of transport: • 27 patients had to reduce dialysis (as confirmed by LTHT) There were 100 'abortive' journeys over the period	
JUL. 2009		30 Jul. 2009 Report to Trust Board proposing not to proceed with the previopusly agreed dialysis unit at LGI.	28 Jul. 2009 Consideration of current proposals regarding delivery of renal services at LGI Update on provision of renal patient transport	

Introduction

1. This position statement has been prepared to reflect the outcome of the Scrutiny Board (Health) meeting, held on 28 July 2009. It is intended to be presented to the Leeds Teaching Hospitals NHS Trust Board at its meeting on 30 July 2009, to inform its consideration on Renal Haemodialysis Satellite Unit at Leeds General Infirmary (LGI).

Background

2. The Scrutiny Board was first advised of the need to close the Wellcome Wing at Leeds General Infirmary (LGI) in February 2006. The decision to close the Wellcome Wing included the decision to reconfigure and re-house services elsewhere in Leeds Teaching Hospitals NHS Trust (LTHT).

3. In March 2006, the Scrutiny Board received an outlined of the proposals to reconfigure Renal Services in Leeds. This included St. James' Hospital becoming the main centre for inpatient renal services with an expanded satellite service, which would be delivered from Seacroft Hospital (via an 18-station dialysis unit), in addition to a new 10–station dialysis unit at the LGI.

4. At that time, the Scrutiny Board did not believe that sufficient consultation had taken place with patients around the reconfiguration proposals. On the recommendation of the Scrutiny Board, further public consultation took place between June and August 2006.

5. The outcome of the consultation and key issues agreed by NHS Leeds and LTHT were reported to the Scrutiny Board in December 2006. This included:

   - Centralisation of in-patient services at St. James's
   - Establishment of a permanent dialysis facility at Seacroft
   - Delivery of a 10-station haemodialysis unit at LGI

6. Since that time, while there have been on-going issues associated with patient transport reported and considered by the Scrutiny Board, there has been no indication or suggestion that the dialysis unit planned for LGI would not be delivered.

7. In early June 2009, via a Kidney Patient Representative, the Chair of the Scrutiny Board first became aware of proposals not to proceed with the LGI dialysis unit as planned. At its meeting on 30 June 2009, the Scrutiny Board agreed to consider these proposals in more detail at its meeting in July 2009.

Witnesses and evidence received

8. In order to gain a rounded view on the proposals, the Scrutiny Board Chair invited input and written submissions from the following organisations:

   - Leeds Teaching Hospital NHS Trust
   - NHS Leeds
   - Specialised Commissioning Group (Yorkshire and the Humber)

- Yorkshire Ambulance Service (YAS)
- Kidney Patients Association (LGI)
- Kidney Patients Association (St. James')
- National Kidney Federation

9. Each of the above organisations provided a written submission. These submissions were presented to the Scrutiny Board and are publicly available. In addition, with the exception of the National Kidney Federation, each organisation was represented at the Scrutiny Board meeting held on 28 July 2009.

10. The acting Chair of the LTHT Board did not attend the Scrutiny Board meeting, but was invited to do so.

Considerations of the Board

11. In considering the evidence presented, the Scrutiny Board also considered issues associated with NHS Trusts' duty to consult, alongside those issues associated with the substantial variation/ development of local health services.

Department of Health (DoH) Guidance

12. Each of the local NHS Trusts has a duty to consult the Scrutiny Board on any proposals it may have under consideration for substantial development or variation in the provision of local health services.

13. NHS Trusts should discuss any proposals for service change at an early stage, in order to agree whether or not the proposal is considered substantial. If proposals are determined as a substantial development or variation, the NHS Trust must formally consult the Scrutiny Board. There should also be discussion with the Scrutiny Board about how consultation will be undertaken more generally.

14. The duty to consult the Scrutiny Board is in addition to the duty placed on NHS Trusts to consult and involve patients and the public as an ongoing process. Government guidance on consultations states that full consultation (involving patients, the public and the Scrutiny Board) should last for a minimum of twelve weeks.

Understanding 'substantial variation and substantial development'

15. There are no regulations that define 'substantial' variation or development. However, Annex 1 outlines the locally agreed definitions of the reconfiguration proposals and stages of engagement/ consultation. Such definitions have previously been used by the Scrutiny Board and its working groups when considering other service change proposals.

Proposed changes to the renal haemodialysis Satellite Unit at Leeds General Infirmary (LGI)

16. In October 2008, the LTHT issued confirmation that a new renal dialysis satellite unit (on Ward 44) at LGI would open in December 2009. This in itself represented a delay in delivering the new unit, but it undoubtedly re-stated the Trust's commitment to providing this facility. As recently as February 2009, it was reported to the NHS Leeds Trust Board that:

'The longer term agreed plan for these stations is to maintain 18 stations at

Seacroft and to relocate 10 stations to a renovated area within LGI. The new unit will open on Ward 44 at Leeds General Infirmary in December 2009. As of October 2008 LTH report that discussions were ongoing with patient representatives regarding the roll out of this development.'

17. Yet in March 2009, the LGI scheme had been withdrawn from the capital programme endorsed by the LTHT Board. This took place without the involvement or knowledge of the kidney patients, the wider population or the Scrutiny Board. It would also appear to have been taken forward without the knowledge or involvement of the service commissioners.

18. In considering the proposals not to proceed with a 10-station dialysis satellite at LGI[4], the Scrutiny Board (Health) has been mindful to consider the general impact of such a change upon patients, carers and the public who use or have the potential to use a service. Specifically, this has included:

Changes in accessibility of services.

19. The Scrutiny Board (Health) has heard contradictory arguments about the potential impact on current/ future patients in the North and North West of the City. The Scrutiny Board is not satisfied with the robustness of data presented in the Trust Board report and believes that additional work, including more informed consultation with patients, needs to be undertaken to fully assess the impact of the current proposals.

Impact of proposal on the wider community

20. The Scrutiny Board (Health) believes that the proposed changes have the potential to affect a significant number of patients receiving haemodialysis. The Board also recognises that this number of patients is predicted to increase year-on-year for the foreseeable future. Therefore, the Scrutiny Board does not feel that the wider public have been adequately involved in formulating the current proposals. Clearly, only through full involvement activity will the commissioners and the Trust be able to take a considered view as to whether the plans are in the interests of local health services.

21. While the Scrutiny Board recognises that investment in the water treatment plant at St. James' is significant and is likely to benefit a large number of kidney patients, the Board fails to understand why this necessary investment was not identified earlier. Indeed, the Scrutiny Board heard evidence to suggest that the necessary maintenance had been identified for some time. As such, the Scrutiny Board believes that the information as presented demonstrates a distinct lack of forward planning and the replacement of the water treatment plant at St. James' should not be at the expense of the long awaited unit at LGI.

Patients affected

22. The Scrutiny Board recognises that the patients currently accessing renal dialysis services (and those

[4] As set out in the LTHT Board report (30 July 2009)

patients likely to access services in the future) will need to do so for many years. As such, the Scrutiny Board does not believe that patients have been sufficiently involved in the most recent developments and formulation of the current proposals.

23. Since early 2006, renal services provision and, in particular, dialysis services across Leeds has been an area considered by the Scrutiny Board on many occasions. On a number of occasions the Board's focus has been on the provision and reliability of transport services for kidney patients. However, consideration of such matters has always been in the knowledge and belief that, in the longer-term, some of the difficulties around patient transport would be resolved by the re-provision of dialysis facilities at LGI. Comments from Yorkshire Ambulance Service reaffirmed that this would be the case for some patients – particularly those accessing services from the North and North–West of the City.

24. The Scrutiny Board considered the evidence presented by the Chief Executive of LTHT and the commissioners, which attempted to demonstrate that there was already sufficient capacity to cater for the current and projected level of demand for renal dialysis services provided by LTHT. However, the Board believes that the location of services and the impact this may have on the quality of life experienced by renal patients, are aspects that should be integrated into any considerations around the capacity of dialysis services. The Scrutiny Board (Health) does not believe that such considerations have been adequately considered in the development of the current proposals.

Methods of service delivery

25. The Scrutiny Board (Health) considered the information associated with the overall approach to renal replacement therapy (RRT). The Scrutiny Board also considered the overall desire to provide local health services closer to home – hearing how the home dialysis service could help alleviate issues around access to services. Nonetheless, the Scrutiny Board also heard how current staffing issues across renal services is having an impact on the timely delivery of home dialysis. If such services are to provide a real alternative to hospital dialysis, there needs to be sufficient evidence that such services have adequate resources and capacity to offer this alternative to a wide group of patients.

26. In addition, the Scrutiny Board believes there is insufficient evidence to demonstrate that the views of patients and carers have been collated and analysed in this regard.

Conclusion and recommendations

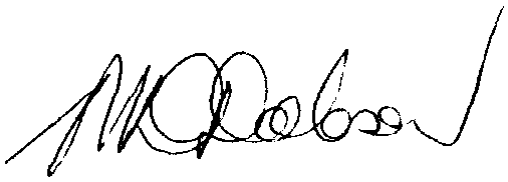
27. Throughout its involvement in considering the provision of renal services across Leeds, the Scrutiny Board's underlying aim has been to ensure that high quality health care services are available for all kidney patients across the City – without adding to patients' often already complicated lives. In light of the process for developing the current proposals, the Board does not believe that the proposals will deliver the necessary quality for all patients.

28. As such, based on the evidence presented to the Scrutiny Board and the Department of Health Guidance on Overview and Scrutiny for Health, this Board believes that the current proposed changes to renal dialysis provision represents a substantial variation to service delivery. As such, the Board feels that a statutory period of consultation is required and should take place prior to any decision of the Leeds Teaching Hospitals NHS Trust (LTHT) Board.

29. Based on the above, the Scrutiny Board recommends that the LTHT Board defer any decision on renal dialysis provision until such consultation has taken place.

30. It should also be recognised that as part of any formal consultation period, there are a number of outstanding issues that the Scrutiny Board would wish to pursue.

On behalf of the Scrutiny Board (Health)



Councillor Mark Dobson (Chair)

29 July 2009

Definitions of reconfiguration proposals and stages of engagement/consultation

Definition & examples of potential proposals	Stages of involvement, engagement, consultation			
	Informal Involvement	Engagement		Formal consultation
Substantial variation or development Major service reconfiguration – changing how/where and when large scale services are delivered. Examples: urgent care, community health centre services, introduction of a new service, arms length/move to CFT				**Category 4** Formal consultation required (minimum twelve weeks) **(RED)**
Significant variation or development Change in demand for specific services or modernisation of service. Examples: changing provider of existing services, pathway redesign when the service could be needed by wide range of people			**Category 3** Formal mechanisms established to ensure that patients/service users/ carers and the public are engaged in planning and decision making **(ORANGE)**	
Minor change Need for modernisation of service. Examples: Review of Health Visiting and District Nursing (Moving Forward Project), patient diaries		**Category 2** More formalised structures in place to ensure that patients/ service users/ carers and patient groups views on the issue and potential solutions are sought **(YELLOW)**		
Ongoing development Proposals made as a result of routine patient/service user feedback. Examples: proposal to extend or reduce opening hours	**Category 1** Informal discussions with individual patients/ service users/ carers and patient groups on potential need for changes to services and solutions **(GREEN)**			

OSC involved

OSC may be involved

Information & evidence base

Information & evidence base

Information & evidence base

14 January 2010

Gateway No: 13393

To: Foundation Trust CEs, NHS Acute Trust CEs, NHS Mental Health Trust CEs, NHS Learning Disability Trust CEs, NHS Ambulance Trust CEs, LINk Chairs and members, OSC Chairs and members

CC: SHA CEs, PCT CEs, SHA Medical Directors

Dear Colleague,

QUALITY ACCOUNTS: Roles of Commissioning PCTs, Local Involvement Networks (LINks) and local authority Overview and Scrutiny Committees (OSCs)

In *High Quality Care for All,* published in June 2008, Ministers set out the Government's vision for putting quality at the heart of everything the NHS does. The report set out that a key component of the new Quality Framework would be a requirement for all providers of NHS services to publish Quality Accounts: annual reports to the public on the quality of health care services they deliver. The aim of Quality Accounts is to improve public accountability and to engage boards in understanding and improving quality in their organisations.

Over the last year, the Department of Health has engaged widely with healthcare providers, commissioners, patient groups and third sector organisations in the development of Quality Accounts and we have recently completed a consultation on our detailed proposals.

One important area that we have considered during this development phase is how to ensure that the information contained in Quality Accounts is accurate (the data used is of a high standard), fair (the interpretation of the information provided is reasonable) and gives a representative and balanced overview.

A key message from our engagement activity was that confidence in the assurance process is key to maximising confidence in the Quality Accounts themselves. Year-round stakeholder engagement during the process of producing a Quality Account was also seen as an important feature to ensure that Quality Accounts are locally meaningful and reflect local priorities.

As a first step, it is intended that providers will have to share their Quality Accounts prior to publication each June with:

- their commissioning PCT (or SHA)*
- the appropriate LINk†
- the appropriate local authority OSC‡

It is intended that the commissioning PCT or SHA will have a legal obligation to review and comment on a provider's Quality Account, while LINks and OSCs will be offered the opportunity to comment on a voluntary basis.

This means that commissioning PCTs, LINks and OSCs will have important roles in the development of Quality Accounts and in maximising their success. We are writing to you now, following the successful completion of the Health Act in November which details the primary legislation for Quality Accounts, to give you advance warning of these important roles.

Timescale for introduction

It is intended that the legal duty to publish a Quality Account will be brought into force from April 2010. Providers will then be required to publish their Quality Account in June each year (starting in June 2010), reporting on the quality of their healthcare services for the previous financial year.

It is intended that Regulations will be made to come into force on the same date as the duty to set out the prescribed information, form and content of Quality Accounts as well as any exceptions to the requirement and the checking and publication process. This letter sets out some of the intentions behind the Regulations and should be used only as preliminary guidance allowing providers, commissioners, LINks and OSCs to prepare for their roles. In order to comply with their legal duties all NHS bodies will need to refer to the final Quality Accounts Regulations and any associated guidance.

It is intended that for the first year the requirement to publish information relating to the quality of services will not apply to primary care services and community healthcare services. Providers that provide other services alongside primary care and/ or community healthcare will only need to produce a quality account for those other services. So for example, Mental Health Trusts that provide both acute and community healthcare will only report on the quality of acute healthcare services provided.

Requirements of Commissioning PCT

It is intended that the commissioning PCT (or SHA) for a provider will be required to

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* The detail of which PCT (or SHA, for providers solely commissioned by an SHA) a provider should send their Quality Account to will be set out in the Regulations. For instance where all the NHS services that an organisation provides are provided under arrangements with one Primary Care Trust, they will send their Quality Account to that PCT. Or for example if an organisation provides NHS services to a number of PCTs which are all co-ordinated by one co-ordinating PCT, then they will send their Quality Account to that co-ordinating PCT.

This includes collaborative commissioning organisations where the PCT has delegated commissioning responsibility to them.

† This will be the LINk or LINks in the local authority area in which the provider's principal office is located.

‡ This will be the OSC in the local authority area in which the provider's principal office is located.

corroborate a provider's Quality Account by confirming in a statement, to be included in a provider's Quality Account whether or not they consider the document contains accurate information in relation to the services provided to it by the provider. In addition they would have to include in the statement any other information they consider relevant to the quality of NHS services provided by the provider for the year reported on.

Coordinating commissioning PCTs will be advised to check the accuracy of data provided in the Quality Account against any data they have been supplied with during the year and reviewed as part of a provider's contractual obligations. PCTs will not be expected to check data that a provider has included in their Quality Account that are not part of existing contract/performance monitoring discussions. The corroborative opinion that the PCT offers will be published in the Quality Account, and will cover issues that the PCT is in a position to comment on. It is not therefore a signing-off of the Quality Account - that remains the responsibility of the provider.

PCTs may wish to seek guidance from their SHA Quality Observatory on the interpretation of data published in providers' Quality Accounts.

Voluntary Role of Local Involvement Networks (LINks) and local authority Overview and Scrutiny Committees (OSCs)

It is intended that providers will have to give both the appropriate LINk and OSC the opportunity, on a voluntary basis, to review and supply a statement, for inclusion in a provider's Quality Account. We would expect this statement to indicate whether they believe, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided and will be issuing guidance accordingly. Depending on local arrangements, an OSC may wish to leave this role entirely to the LINk (or vice versa) and this should be agreed between the two organisations.

Further advice on these roles is provided in Annex 1. We appreciate that for the first year of Quality Accounts those providing assurance over Quality Account will not have had the full financial year to work with providers in the Quality Accounts development process and that developing these new roles will be a challenge.

The Department is keen to learn from the first year of Quality Accounts and will seek feedback on the experiences of all involved to continuously improve the process year on year.

The intended requirements to be placed on PCTs and the roles envisaged for LINks and OSCs, will form important elements of an assurance package for Quality Accounts that can be built on over time. Another element of the proposed assurance package is the self-certification from a senior employee of each provider that they are accountable for the content of the Quality Account. The National Quality Board (NQB) is currently reviewing possible additional levels of assurance and we will write to you about these at a future date.

Yours sincerely,

Professor Sir Bruce Keogh, NHS Medical Director, Department of Health

Queries and additional information

Any queries about the Department's work on Quality Accounts should be addressed to:-

Neil Townley
NHS Medical Directorate
5th Floor Skipton House
80 London Road
London SE1 6LH
Tel: 0207 972 5209
Email: QualityAccounts@dh.gsi.gov.uk

Annex 1 – Further information on the intended assurance roles and requirements of providers, commissioning PCTs, LINks and OSCs.

Providers producing Quality Accounts

It is proposed that providers will be required to send a copy of their Quality Account to:

- their commissioning PCT
- the appropriate LINk(s)
- the appropriate local authority OSC

and to include statements supplied by the above stakeholders in their published Quality Account provided certain conditions are met, for example in relation to the length and content of such statements.

DH guidance will advise that in order for this process to run smoothly, providers should share their proposed content and the data that they plan to use at an early, separate, stage with commissioners, LINks and OSCs and ideally this should be part of year-round ongoing discussions.

Early discussions and the sharing of drafts will allow stakeholders to raise any initial concerns with a provider's Quality Accounts. It will allow PCTs to prepare for their role in the assurance process of checking data accuracy (where data is available to them) and that the Quality Account fairly represents and interprets this data. The provision of contextual and background information will assist stakeholders in their consideration of the information provided in a Quality Account will also help LINks and OSCs prepare for their roles.

It is intended that if providers do not receive a statement from their commissioner prior to publication, then they should publish their Quality Account without it in order to meet the deadline for publication.

Commissioning PCTs

It is proposed that PCTs will be directed (under the National Health Service Act 2006) to:

- confirm in a statement, to be included in a provider's Quality Account, whether or not they consider the document contains accurate information in relation to services provided to it and set out any other information they consider relevant to the quality of NHS services provided;
- take reasonable steps to check the accuracy of data provided in the Quality Account against any data they have been supplied with during the year (eg. as part of a provider's contractual obligations).

Any narrative provided should be published verbatim as part of a provider's Quality Account.

Providers should give PCTs at least 30 working days to prepare their comments on the Quality Account and send back to the provider, prior to publication. The statement should also be written (and published by the provider) if the PCT is of the view that the Quality Account is not representative and highlight any areas of concern.

DH guidance will advise that providers and commissioners discuss at an early stage, the providers proposed content of their Quality Account to ensure that it includes areas that have been identified as being local priorities.

Providers will determine the content of their Quality Accounts, including the use of indicators to describe the quality of their healthcare services. This means that a provider's Quality Account may contain content in addition to that used for performance monitoring. PCTs will not be expected to check the accuracy of any data that a provider has included in their Quality Account that are not part of existing contract/performance monitoring discussions.

PCTs may wish to seek guidance from their SHA Quality Observatory in the interpretation of data published in providers' Quality Accounts.

Before providing a statement on a provider's Quality Account, PCTs may wish to consult with other PCTs, regional specialised commissioning groups or acute commissioning hubs where substantial activity (for instance specialised services) is provided to patients outside their area.

Local Involvement Networks (LINks)

It is proposed that providers will be required to send a draft of their Quality Account, to the appropriate LINk(s) and to include any statement supplied in their published Quality Account.

LINks will be invited on a voluntary basis to:

- comment on a provider's Quality Account

LINks might like to comment on the following areas:

- whether the Quality Account is representative
- whether it gives a comprehensive coverage of the provider's services
- whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to Quality Accounts.

Any narrative provided should be published verbatim as part of a provider's Quality Account.

We recommend that LINks should let the provider know if they do not intend to provide a statement.

Providers should give LINks at least 30 working days to prepare their comments on the Quality Account and send back to the provider, prior to publication. The statement should also be written (and published by the provider) if the LINk is of the view that the Quality Account is not representative and highlight any areas of concern.

DH guidance will advise that providers and LINks discuss at an early stage, the provider's proposed content of their Quality Account to ensure that the report covers areas of importance to the local community. To ensure that the local relevance of the Quality Account is maintained, a year-round dialogue between LINks and providers is envisaged.

Before providing a statement on a provider's Quality Account, LINks may wish to consult with other LINks where substantial activity, for instance specialised services, is provided to patients outside their area.

Overview and Scrutiny Committees (OSCs)

Providers will be required through Regulations to send a draft of their Quality Account, to the appropriate OSC and to include any statement supplied in their published Quality Account.

OSCs will be invited on a voluntary basis to:

- comment on a provider's Quality Account

OSCs might like to comment on the following areas:

- whether the Quality Account is representative
- whether it gives a comprehensive coverage of the provider's services
- whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to Quality Accounts.

Any narrative provided (maximum 500 words) should be published verbatim as part of a provider's Quality Account.

We recommend that OSCs should let the provider know if they do not intend to provide a statement.

Providers should give OSCs at least 30 working days to prepare their comments on the Quality Account and send back to the provider, prior to publication. The statement should also be written if the OSC is of the view that the Quality Account is not representative and highlight any areas of concern.

DH guidance will advise that providers and OSCs discuss at an early stage, the providers proposed content of their Quality Account to ensure that the report covers areas of importance to the local community. To ensure that the local relevance of the

Quality Account is maintained, a year-round dialogue between OSCs and providers is envisaged.

LINks and OSCs are invited to comment on a provider's Quality Account on a voluntary basis. Depending on local arrangements, an OSC may wish to leave this role entirely to the LINK (or vice versa) and this should be agreed between the two organisations.

Before providing a statement on a provider's Quality Account, OSCs may wish to consult with other OSCs where substantial activity, for instance specialised services, is provided to patients outside their area.

Role of LINks and OSCs in providing information to CQC

It is recognised that LINks and OSCs already have an important role in providing information about a provider to CQC. This information was previously provided to the Health Care Commission in the form of an annual health check. LINks and OSCs can now share information with CQC about NHS providers at any time during the year. This information will be used to inform the new system of registration, ongoing monitoring of providers and future quality assessments of their services. CQC will take into account statements made by a LINk/OSC as part of their review of the provider.

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 26 January 2010			

Scrutiny Inquiry – promoting good public health	**Session 2 - continued:**
	To consider issues associated with ***reversing the rise in levels of obesity and promoting an increase in the levels of physical activity***, such as:
	• The role of the Council and its NHS health partners in developing and delivering appropriate strategies that:
	  ○ Raises general public awareness of the health risks associated with obesity and inactive lifestyles.
	  ○ Identifies and targets those groups most at risk of becoming obese and leading inactive lifestyles.
	  ○ Assesses the quality and effectiveness of services and treatments associated with obesity.
	  ○ Promotes easy access to leisure facilities and activities.
	• The role of the Council in terms of its power of well-being through planning policies and associated enforcement/ control procedures.
	The role of commercial sector partners in promoting healthier lifestyles.
		Carried over from December 2009	RP/DP

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 16 February 2010			

Scrutiny Inquiry – promoting good public health	**Session 3:**
	To consider issues associated with ***promoting responsible alcohol consumption***, such as:
	• The role of the Council in terms of licensing policy and associated enforcement/ control procedures.
	• The role of the Council and its NHS health partners in developing and delivering an alcohol strategy that:
	  ○ Raises general public awareness of the health risks associated with alcohol consumption.
	  ○ Identifies and targets those groups most at risk from the affects of alcohol abuse, ensuring they have access to the most appropriate services and treatments.
	  ○ Assesses the quality and effectiveness of services and treatments associated with reducing alcohol related harm.
	• The social responsibility role of breweries, retailers and licensees and how this shapes the consumption of alcohol in Leeds.
			B/RP

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 16 March 2010			
Update on local NHS priorities	To consider an update on the previously identified priorities for each local NHS Trust.	Updates from: • NHS Leeds • Leeds Teaching Hospitals NHS Trust • Leeds Partnerships NHS Foundation Trust	PM
Quarterly Accountability Reports	To receive quarter 3 performance reports		PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Meeting date – 27 April 2010			
Scrutiny Inquiry – promoting good public health	To agree the Board's final inquiry report.	Timing to be confirmed	
Annual Report	To agree the Board's contribution to the annual scrutiny report		

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2009/10

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Proposals Working Group	*All Scrutiny Board members. Core membership of Cllr. Dobson and Cllr. Chapman*	• Working group re-established and terms of reference agreed. • Membership established • First meeting held on 3 December 2009	*3 December 2009*
Supporting working age adults with severe and enduring mental health problems		**This inquiry is being undertaken by the Scrutiny Board (Adult Social Care) with nominated representatives from Scrutiny Board (Health)** • Working group re-established and terms of reference agreed. • Membership established • Initial meeting dates arranged	*19 October 2009* *15 December 2009*
Scrutiny Inquiry – promoting good public health	*To be agreed*	Proposed working group to consider issues around smoking and any other outstanding matters associated with the inquiry and identified by the Scrutiny Board	*To be agreed*

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Renal services in Leeds	To consider the responses to the Scrutiny Board's statement and specific recommendations.	A further report to be considered as soon as practicable.
Provision of dermatology services	To consider further progress in developing future plans for delivery of the service.	A report on progress and any further development will be provided to the Scrutiny Board in due course and before the end of the current municipal year
Use of 0844 Numbers at GP Surgeries	To consider the impact of the recent Government guidance on local GP practices and any implications for patients.	Various correspondence exchanged and clarification sought. The Board to maintain a watching brief and kept up-to-date with any developments

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Openness in the NHS	To consider how the Department of Health guidance is interpreted and implemented locally.	An outline of the approach adopted by the local NHS Trusts requested. Responses from NHS Leeds and LPFT received. Reply from LTHT awaited.
Children's Cardiac Surgery Services	To contribute to the national review and consider any local implications.	First newsletter published (August 2009) National stakeholder event held 22 October 2009. Draft clinical standards issued for consultation. Clarification sought on local involvement and engagement activity.
Children's Neurosurgery Services	To contribute to the national review and consider any local implications.	First bulletin published (September 2009) National stakeholder event held 30 November 2009. Clarification sought on local involvement and engagement activity.

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Quality Accounts	Potential input of the scrutiny Board in local Trust's production of the require reports.	Input to be agreed
Narrowing the Gap	To consider the impact of the 'Narrowing the Gap' initiative, in terms of improving healthy outcomes.	Added to the work programme: December 2009
Primary Care Service Development and use of the Capital Estate	In the light of NHS Leeds' decisions to withdraw from projects in Kirkstall and Holt Park, to consider the PCT's longer-term strategy for developing services through its capital estate.	Added to the work programme: December 2009
Health Scrutiny – Department of Health Guidance	To receive and consider revised guidance associated with health scrutiny and any implications for local practice.	Guidance was due to be published in November 2009. Indications are that this is likely to be delayed. No firm publication dates are yet available.
Specialised commissioning arrangements	To consider the current arrangements for specialised commissioning within the region and the role of scrutiny.	The planned Department of Health (DoH) consultation on developing / strengthening Health Scrutiny may have an impact.

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Hospital Discharges	To consider a follow up report on progress against the recommendations (i.e. 15, 16 and 17) detailed in the Independence, Wellbeing and Choice inspection report	Consider report in September/ October 2009.
Out of Area Treatments (Mental Health)	To consider the report prepared by Leeds Hospital Alert and the response from LPFT.	Leeds Hospital Alert report received 1 July 2009. Response from LPFT requested on 1 July 2009.

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

EXECUTIVE BOARD

WEDNESDAY, 9TH DECEMBER, 2009

PRESENT: Councillor A Carter in the Chair

Councillors R Brett, J L Carter, R Finnigan, S Golton, R Harker, P Harrand, J Monaghan, J Procter and K Wakefield

Councillor R Lewis – Non-Voting Advisory Member

126 Retirement of Deputy Chief Executive - Dave Page

On behalf of the Board, the Chair paid tribute to and thanked the Deputy Chief Executive, Dave Page for his services to the Council, as this would be the final Board meeting in which he would be in attendance prior to his retirement.

127 Technoprint Court Case

The Board was advised that following the recently announced verdict, the High Court had ruled in the Council's favour with respect to the Court Case regarding the company Technoprint. The Chair thanked all of those officers involved for their efforts throughout the case.

128 Exempt Information - Possible Exclusion of the Press and Public

The substantive reports and assessment documents referred to in Minute Nos. 135 and 136 had been designated as exempt until 3rd December and 9th December 2009 respectively. This designation had arisen from embargoes on the documents which had substantially been the source of the contents of those items and all information had been published on the lifting of those embargoes.

RESOLVED – That the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendix 1 to the report referred to in Minute No. 133 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the appendix contains information which if disclosed to the public would, or would be likely to prejudice the commercial interests of the Council.

(b) Appendix 1 to the report referred to in Minute No. 150 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the appendix contains information relating to the financial or business affairs of a particular person and of the Council, and is not

publicly available from the statutory registers of information kept in respect of certain companies and charities.

It is considered that since the information was obtained through one to one negotiations for the disposal of the property/land then it is not in the public interest to disclose the information at this point in time. Also, it is considered that the release of such information would or would be likely to prejudice the Council's commercial interests in relation to other similar transactions in that prospective purchasers of other similar properties could obtain information about the nature and level of consideration which may prove acceptable to the Council.

It is considered that whilst there may be a public interest in disclosure, much of this information will be publicly available from the Land Registry following completion of the transaction and consequently the public interest in maintaining the exemption outweighs the public interest in disclosing the information at this point in time.

129 Late Items

The Chair admitted the following late item to the agenda:-

Key Decision Taken Under Special Urgency Provisions (Minute No. 157 refers)

Following a Key Decision being taken under the Special Urgency provisions, a report providing details of the decision and recommending that it be forwarded to Council as the quarterly report of the Leader on such decisions was submitted to Executive Board in accordance with Access to Information Procedure Rules. Due to the urgent nature of the Key Decision, it was considered appropriate for this report to be submitted to the next scheduled meeting of the Board.

130 Declaration of Interests

Councillor Wakefield declared personal interests in the items referred to in Minute Nos. 152, 153, 155 and 156, due to his position as a school and college governor.

Councillor Brett declared a personal interest in the item referred to in Minute No. 136 due to being a Board Member of Leeds Ahead.

Councillor J Procter declared a personal interest in the item referred to in Minute No. 133, due to his position as Chair of the Leeds Grand Theatre and Opera House Board of Management, and a personal and prejudicial interest in the item referred to in Minute No. 144 due to having a commercial interest in a biomass company.

Councillor Harrand declared a personal interest in the item referred to in Minute No. 133, due to his position on the Leeds Grand Theatre and Opera House Board of Management.

Councillor Finnigan declared personal interests in the items referred to in Minute Nos. 153 and 154, due to his position as a school governor.

Councillor R Lewis declared personal interests in the items referred to in Minute Nos. 153 and 154, due to his position as a school governor.

Councillor A Carter declared personal interests in the items referred to in Minute Nos. 153 and 154, due to his position as a school governor.

131 Minutes

RESOLVED –

(a) That subject to the figure £1,000,500 being deleted from minute 112(b) and being replaced with the sum of £1,500,000, the minutes of the meeting held on 4th November 2009 be approved as a correct record.

(b) That the minutes of the meeting held on 24th November 2009 be approved as a correct record.

LEISURE

132 Design and Cost Report for the Redevelopment of Middleton Park Through a Heritage Lottery Fund Parks for People Grant

The Director of City Development submitted a report providing an update on the development of the Stage 2 Parks for People Heritage Lottery Fund bid for Middleton Park, detailing proposals to progress the scheme and which sought approval for the submission of the bid on or before the 31st December 2009.

RESOLVED –

(a) That the injection of £1,797,929 into the 2010/11 Capital Programme be approved.

(b) That the submission of the Stage 2 bid on or before the 31st December 2009 be approved.

(c) That the use of the Parks Renaissance funding scheme number 12523 to address the £68,500 shortfall in the scheme be approved.

(d) That the current position in relation to the surrender of the lease and the sale of 218 and 220 Middleton Town Street, which is providing part of the Council's match funding for the project, be noted.

(e) That the Heads of Terms for the contribution agreement between Leeds City Council and Wades Charity be agreed, and that delegated authority to the Council's Chief Recreation Officer to complete the agreement be approved.

133 City Varieties Music Hall Refurbishment: Project Update

Further to minute 222, 4th March 2009, the Director of City Development submitted a report providing an update on the refurbishment of the City

Varieties Music Hall with reference to a revised timetable for completion. The report also sought authority to spend additional funding on the project.

Following consideration of Appendix 1 to the report, designated as exempt under Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting it was

RESOLVED – That the contents of the report, including the update on the scheme be noted, and that the recommendation contained within exempt Appendix 1 be approved.

ADULT HEALTH AND SOCIAL CARE

134 KPMG Health Inequalities Report

The Director of Adult Social Services submitted a report presenting the recommendations arising from a review of health inequalities undertaken by KPMG, detailing the responses to the recommendations and outlining proposed further actions to raise awareness of health inequalities across the City.

RESOLVED –

(a) That the findings of the KPMG audit on health inequalities be welcomed, and that the action plan appended to the submitted report which has been prepared in response to the recommendations be endorsed.

(b) That the implications for Council policy and governance, as set out in section 5 of the submitted report, be noted.

(c) That the Director of Adult Social Services be requested to prepare further reports as appropriate on the development of partnership working with NHS Leeds.

135 Annual Performance Assessment for Adult Social Services

The Director of Adult Social Services submitted a report providing the outcome of the Care Quality Commission Annual Performance Assessment of Adult Social Services for 2008/09.

The Board extended its thanks to all staff within Adult Social Care who had helped to ensure that Adult Social Care provision in the city had been judged to be 'Performing Well'.

Due to the outcome of the Annual Performance Assessment being embargoed until 3rd December 2009, a substantive report providing full details of the outcome was circulated to Members for consideration once the embargo had been lifted.

RESOLVED –

(a) That the contents of the submitted report, the final assessment letter and the performance review report from the Care Quality Commission for adult social care services in 2008/09 be noted.

(b) That the areas for improvement, as set out in the annual performance rating report, be referred to the Scrutiny Board (Adult Social Care) for the Scrutiny Board's oversight of performance.

CENTRAL AND CORPORATE

136 Comprehensive Area Assessment 2009

The Assistant Chief Executive (Planning, Policy and Improvement) submitted a report presenting the outcomes from the 2009 Comprehensive Area Assessment for Leeds.

Members noted that a further report specifically in relation to Children's Services would be submitted to the next meeting of the Board.

Due to the outcomes of the Comprehensive Area Assessment being embargoed until 9th December 2009, the Area Assessment report, Organisational Assessment report and the Ofsted letter with respect to the Children's Services Annual Rating were tabled at the meeting for Members' consideration once the embargo had been lifted.

RESOLVED – That the covering report and the published reports which provide details of the outcomes from the Comprehensive Area Assessment 2009 be received.

137 Corporate Performance Report 2009/10 Quarter 2

The Assistant Chief Executive (Planning, Policy and Improvement) submitted a report presenting an overview of performance against the Council's priority outcomes for the first 6 months of the 2009/10.

RESOLVED – That the overall performance position at Quarter 2 with respect to the strategic priorities, and the action planned to further improve or address performance concerns, be noted.

138 Design and Cost Report: Business Transformation in Leeds City Council and the Introduction of Employee and Manager Self Service

The Director of Resources submitted a report regarding the development and deployment of SAP's Manager and Employee Self Service module as part of the Council's wider transformation agenda.

RESOLVED – That authority be given to spend £1,465,500 over the next 2 year period (plus an additional £117,500 in year 5), to be funded from the Business Transformation allocation and the ICT Development and equipment funds, in order to enable the implementation of the Manager and Employee Self Service initiative to contribute towards the delivery of Business Transformation within Leeds City Council.

139 Progress Report on the PPP/PFI Programme In Leeds

A report was submitted by the Deputy Chief Executive providing an update on the Council's current portfolio of PPP/PFI projects and programmes, highlighting the planned key activities earmarked for the investment programme, identifying the employment opportunities which have been created and detailing information on the recent review of governance arrangements for such projects.

RESOLVED –

(a) That the current status of the PPP/PFI projects and programme be noted.

(b) That the winding up of the Coordination Board and the transfer of responsibilities to Directors, with effect from the date of approval of the amendments to Director delegations by the Leader, as outlined at section 6 of the submitted report, be approved.

(c) That the proposed revised Terms of Reference for the Strategic Investment Board (SIB) be noted.

(d) That the Deputy Chief Executive, and subsequently the Director of Resources and Deputy Chief Executive be authorised to implement any necessary Project Board changes, in terms of structure, Chair and composition, as detailed within paragraph 7.1.1 of the submitted report.

(e) That the proposal detailed at paragraph 7.2 of the submitted report in relation to Final Business Case approvals be noted.

140 Consultation Response - Transitional Arrangements for Regulation of Lap Dancing Clubs

The Assistant Chief Executive (Corporate Governance) submitted a report on the reclassification of lap dancing establishments, and on the proposed response to the public consultation exercise undertaken on the transitional arrangements for the regulation of such establishments.

RESOLVED – That the proposed responses to the consultation be noted and endorsed as the Council's response.

DEVELOPMENT AND REGENERATION

141 A65 Quality Bus Initiative

The Director of City Development submitted a report providing an update on the progress made in relation to the A65 Quality Bus Initiative and outlining the necessary approvals required to continue the development of the Initiative.

RESOLVED –

(a) That the contents of the submitted report be noted, and prior to the Full Approval being granted by the Department for Transport, the following be approved:

i) the additional fee expenditure of £126,000.

ii) the remaining ECI Contract costs of £175,000.

iii) the mobilisation and start up costs of £180,000.

iv) further advance payments to statutory undertakers at a cost of £455,000.

(b) That following Full Approval being granted by the Department for Transport, approval be given to:

i) rescind all previous approvals.

ii) the implementation of the A65 Quality Bus Initiative scheme at a total cost of £21,580,000.

iii) incur expenditure of £14,880,000 works, £2,000,000 land, £2,300,000 statutory undertakers and £2,400,000 fees, all of which is included within the approved capital programme.

142 Leeds Local Development Framework - Annual Monitoring Report 2009

The Director of City Development submitted a report presenting the proposed Local Development Framework Annual Monitoring Report 2009 for submission to the Secretary of State for Communities and Local Government.

The Board noted that an amendment to the Annual Monitoring Report 2009 document had been proposed, namely the replacement of paragraph 7.1.5 with the following:

'Overall waste arisings continue to decrease. Moreover, management methods of recycling and composting are increasing their share of total management. This is also encouraging as it means less waste is being diverted to landfill'.

RESOLVED – That, subject to the incorporation of the above amendment, the Leeds Local Development Framework Annual Monitoring Report 2009 be approved for submission to the Secretary of State, pursuant to Regulation 48 of the Town and Country Planning (Local Development) (England) Regulations 2004.

143 Business Support Scheme for the Council's Small Business Tenants and Investment in Kirkgate Markets

The Director of City Development submitted a report regarding the proposed establishment of a Business Support Scheme to support the Council's commercial tenants in the markets, estate shops, miscellaneous small shops

and small industrial units, whilst also outlining the financial implications of establishing such a scheme.

RESOLVED –

(a) That the establishment of a Business Support Scheme for the Council's small independent business tenants be agreed.

(b) That £250,000 revenue be earmarked to establish the scheme, with £50,000 released from Contingency Fund in 2009/10.

(c) That further decision making on the details of the scheme and the terms and conditions for giving support be delegated to the Director City Development in consultation with the Executive Member for Development and Regeneration.

(d) That officers be requested to monitor the scheme and its effectiveness, and to report back to Executive Board in six months time.

(e) That £125,000 be injected in 2010/11 and £125,000 be injected in 2011/12, when the Capital Programme is reviewed in February 2010, in order to improve facilities at Kirkgate Market.

(f) That the proposed Lower Kirkgate Townscape Heritage Initiative (THI) bid to the Heritage Lottery Fund be the subject of a separate report.

ENVIRONMENTAL SERVICES

144 Climate Change Action Plan (and Eurocities Declaration on Climate Change)

The Director of City Development submitted a report regarding the proposed adoption and publication of the Leeds Climate Change Action Plan, in addition to the approval and signing of the Leeds Climate Change Charter and the Eurocities Declaration on Climate Change.

RESOLVED –

(a) That the Leeds Climate Change Action Plan be adopted and made public.

(b) That the Leeds Climate Change Charter and the Eurocities Declaration on Climate Change be signed on behalf of the Council.

(c) That the current target to reduce corporate CO_2 emissions by 33.4% by 2020/21 be amended, and a stretch target to reduce corporate CO_2 emissions by at least 40% by 2020/21 be adopted, as referred to in paragraph 4.6 of the submitted report.

(Having earlier declared a personal and prejudicial interest in relation to this item, Councillor J Procter left the room during the consideration of this matter)

145 Recycling Improvement Plan

The Director of Environment and Neighbourhoods submitted a report providing an update on recycling performance, outlining the progress made with respect to the provision of kerbside recycling and which proposed the initiation of a Recycling Improvement Plan.

RESOLVED –

(a) That the initiation of the Recycling Improvement Plan be approved.

(b) That the aims, guiding principles and programmed approach to giving equality of access, but not necessarily uniform methods of recycling, across the city, be endorsed.

(c) That the additional costs of extending the garden waste collection service and how these costs can be met in the future by driving through the agreed efficiency improvements in the Waste Collection Service be noted.

NEIGHBOURHOODS AND HOUSING

146 Deputation Response - Residents Concerned at Levels of Local Authority Provision for the Travelling Community

The Director of Environment and Neighbourhoods submitted a report in response to the deputation to Council on 15th July 2009 submitted by local residents concerned at levels of local authority provision for the travelling community.

A revised version of the verbatim record of the deputation, which was appended to the submitted report, had been circulated for Members' information prior to the meeting.

RESOLVED – That the response to the deputation, as contained within the submitted report, be noted.

147 Regional Housing Board Programme 2008-11 - Update on schemes within the overall programme

The Director of Environment and Neighbourhoods submitted a report outlining the changes to the funding position and proposing a revised resource programme for the Regional Housing Board 2008/11 which was within the reduced funding available.

RESOLVED –

(a) That due to the reduced funding position and the resource allocations, the revised investment programme be agreed.

(b) That an additional £307,367 energy efficiency grant funding be injected into the 2009/10 capital programme.

(c) That additional private sector contributions of £151,100 be injected into the programme and that expenditure be authorised as detailed at

Appendix B to the submitted report, which is earmarked for Cross Green Phase 3 A&D scheme.

(d) That authority to spend on the schemes as detailed in Appendix B to the submitted report be rescinded.

(e) That all remaining individual authority to spend requests be brought forward to Executive Board or the appropriate Director as per the Financial Procedure Rules.

148 Leeds Housing Strategy 2009 - 2012/Leeds Private Rented Housing Strategy

The Director of Environment and Neighbourhoods submitted a report presenting for approval the updated Leeds Housing Strategy 2009 - 2012 and the updated Leeds Private Rented Housing Strategy.

RESOLVED – That the updated Leeds Housing Strategy 2009 – 2012 and the updated Private Rented Housing Strategy be approved.

149 Little London and Beeston Hill and Holbeck PFI Project - Demolition of Empty Properties Prior to the Start of the PFI Contract

Further to minute 214, 4th March 2009, the Director of Environment and Neighbourhoods submitted a report proposing the demolition of a number of tower blocks and maisonette properties which have been emptied in readiness for the Little London and Beeston Hill and Holbeck PFI project, in advance of the start of the PFI contract.

RESOLVED –

(a) That the demolition of the identified empty properties in Little London and Holbeck be approved.

(b) That the injection of £1,700,000 into the Capital Programme, from the use of Unsupported Borrowing be approved.

(c) That scheme expenditure of £1,700,000 be authorised.

150 Council House Building - 25 Properties for the Over 55s

The Director of Environment and Neighbourhoods submitted a report outlining a proposal to release monies, dispose of land at nil consideration and appoint builders for the provision of 25 two bed properties for the over 55s.

The report detailed the following options available to progress the development of the sites involved, with option 3 being recommended as the preferred option:

Option 1 - Sell the land at Waterloo on the open market for £500,000 which would deliver 20 open market units and 9 affordable units. The land at Silver Royd and Evelyn Place could be sold on the open market for £210,000 which would deliver 17 units and no affordable units as the size of the sites would be below the threshold for affordable housing. This option would result in a

capital receipt of £710,000 and 9 units of affordable housing. However this would rely on an open market sale which would not be likely due to present market conditions, and so would instead, leave all three sites undeveloped for the foreseeable future and no new council properties.

Option 2 - As the Waterloo Site was already in the remit of the Strategic Affordable Housing Partnership Board this could be sold to a Registered Social Landlord (RSL) for a capital receipt of £ £145,000. Subject to receiving a grant from the Homes and Community Agency (HCA) this could result in 29 affordable units being delivered by an RSL. The sites at Silver Royd and Evelyn Place being sold on the open market for £210,000 and no affordable housing on those two sites. This option would result in a capital receipt of £355,000 and 29 units of affordable housing would be delivered via an RSL on the Waterloo Road site. This would be dependant on a grant being secured from the HCA and would leave the other two sites undeveloped for the foreseeable future and would result in no new council properties.

Option 3 - Sell the land at Waterloo Road for nil consideration to Keepmoat PLC and issue a licence to allow Keepmoat PLC to build on the Councils behalf, at Evelyn Place and Silver Royd. Use £1,516,424, Section 106 monies to purchase 25 completed units across the 3 sites. This option would result in no capital receipt for the Council but retained ownership of land at Silver Royd and Evelyn Place and 25 new council properties to be owned by the Council and managed by West North West Homes. This option would also ensure that all three sites were developed, bringing additional work and confidence to these areas. Across the three sites this would equate to 55% new council housing.

Following consideration of Appendix 1 to the report designated as exempt under Access to Information Procedure Rule 10.4(3), which was considered in private at the conclusion of the meeting it was

RESOLVED –

(a) That the appointment of Keepmoat PLC to build the new properties on behalf of the Council be authorised.

(b) That £1,516,424 of Section 106 funding be injected into the Capital Programme.

(c) That expenditure of £1,516,424 be authorised to acquire 25 x 2 bed properties for the over 55s funded through Section 106 resources.

(d) That land at Waterloo Road, as detailed within the submitted report, be disposed of at nil consideration.

CHILDREN'S SERVICES

151 Proposed Variations to the BSF Capital Programme

The Deputy Chief Executive and the Director of Children's Services submitted a joint report outlining proposed budgetary variations to the BSF Capital

Programme and providing information on the outcome of the Compensation Event Claims arising from the Phase 1 Design and Build contract.

RESOLVED –

(a) That the contents of the submitted report be noted.

(b) That £683,000 be injected into the Education Capital Programme to reflect the additional funding notified by the Partnerships for Schools.

(c) That £800,000 be injected into the Education Capital Programme to reflect the current asset valuation of Wortley High School.

(d) That the proposed changes to the profile of spend against the proposed Programme Contingency, including the incorporation of the two sums injected at (b) and (c) be agreed, and that authority to spend against this budget in line with the profile detailed within the submitted report and Appendix 1 be approved.

(e) That an injection of £300,000 into the Education Capital Programme to reflect the current asset valuation of Pudsey Grangefield School be approved.

152 Transfer of Responsibilities from the LSC to the Local Authority

The Director of Children's Services and the Chief Executive of Education Leeds submitted a joint report providing an update on the progress made with respect to the transfer of responsibilities from the Learning and Skills Council to the Local Authority and in relation to the future arrangements for the planning and funding of 14-19(25) provision at local authority and sub-regional level.

RESOLVED –

(a) That the progress made with respect to the transfer of responsibilities from the Learning and Skills Council to the Local Authority be noted, and that the approach to the preparation for the transfer of such responsibilities be approved.

(b) That support for Elected Member representation on the reconstituted 14-19 Strategic Partnership, as indicated at paragraph 3.1.3 of the submitted report be confirmed.

(c) That the Memorandum of Understanding, as detailed at appendix 3 to the submitted report, be approved.

153 Proposal for Statutory Consultation for the Expansion of Primary Provision for September 2011

The Chief Executive of Education Leeds submitted a report outlining proposals to undertake a statutory formal consultation exercise with respect to the proposed permanent expansion of those primary schools detailed within the report.

The Board was advised that the proposed capacity in relation to West End Primary should have read 315, rather than the 420 as detailed within appendix 1 to the report.

RESOLVED –

(a) That subject to the above amendment, the statutory formal consultation on the prescribed alterations to permanently expand the primary schools identified within Appendix 1 to the submitted report, be approved.

(b) That a report detailing the outcome of the consultations be submitted to Executive Board in Spring 2010.

(c) That the proposals for further primary school expansions from 2012 onwards, which will be the subject of further reports to the Board, be noted.

154 Proposal to Relocate the West SILC from the Farnley Park Site under Building Schools for the Future

The Chief Executive of Education Leeds submitted a report outlining proposals to undertake formal consultation on the relocation of the West Specialist Inclusive Learning Centre (SILC) (Victoria Park) modular building at Farnley Park Maths and Computing college to Bruntcliffe High School.

RESOLVED –

(a) That a formal consultation process be undertaken on the relocation of the provision currently made in the West SILC (Victoria Park) modular building at Farnley Park Maths and Computing College, as planned under the Building Schools for the Future initiative.

(b) That a further report be submitted to the Board in March 2010 reporting on the outcome of the consultation commencing in January 2010.

155 Outcomes for Looked After Children in Leeds

To consider the report of the Director of Children's Services summarising the progress made against the Every Child Matters outcomes with respect to Looked After Children in Leeds, and which identifies the strategies for improving such outcomes.

RESOLVED – That the main findings detailed within the submitted report, and its conclusions, be noted.

156 Children's Trust Arrangements - Area and Locality Governance Arrangements

The Director of Children's Services submitted a report outlining proposals with respect to formal arrangements for the area and locality aspects of the children's trust arrangements in Leeds. In addition, the report set out the context for such proposed developments and provided supporting background information and analysis.

RESOLVED –

(a) That the need to establish formal procedures for the area and local working of children's trust arrangements in Leeds be noted.

(b) That the proposed approach to the development of area and locality Children Leeds Partnerships, as set out in Section 5 of the submitted report and appendices, be approved.

(c) That the children's trust arrangements in Leeds be updated in accordance with the proposals detailed within the submitted report.

157 Key Decision Taken Under Special Urgency Provisions - Buslingthorpe Conservation Area

The Assistant Chief Executive (Corporate Governance) submitted a report informing of a Key Decision taken under the 'Special Urgency' provisions contained within the Constitution with respect to Buslingthorpe Conservation Area. The report recommended that it was forwarded to Council as the quarterly report on such decisions in accordance with paragraph 16.3 of the Access to Information Procedure Rules.

The report relating to this matter had been circulated to Members for their consideration prior to the meeting.

RESOLVED –

(a) That the report be approved as the report of the Leader for submission to Council as the quarterly report in accordance with Access to Information Procedure Rule 16.3.

(b) That this decision be exempt from Call In due to being concerned with matters which are reserved to Council.

DATE FOR PUBLICATION: 11TH DECEMBER 2009
LAST DATE FOR CALL-IN: 18TH DECEMBER 2009

(Scrutiny Support will notify Directors of any items called in by 12:00 noon on 21st December 2009)

EXECUTIVE BOARD

WEDNESDAY, 6TH JANUARY, 2010

PRESENT: Councillor A Carter in the Chair

Councillors R Brett, J L Carter, R Finnigan, S Golton, R Harker, P Harrand, J Monaghan, J Procter and K Wakefield

Councillor R Lewis – Non-Voting Advisory Member

158 Exclusion of the Public

RESOLVED – That the public be excluded from the meeting during consideration of the following parts of the agenda designated as exempt on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendices 1 and 2 to the report referred to in minute 171 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosing the information as disclosure could be prejudicial to the commercial interests of the Council.

159 Declaration of Interests

Councillor Wakefield declared personal interests in the matters referred to in minutes 161, 162, 163, and 164 as a school and college governor.

160 Minutes

RESOLVED – that the minutes of the meeting held on 9th December 2009 be approved.

CHILDREN'S SERVICES

161 The Future of Primrose, City of Leeds and Parklands Girls High Schools, and of Girls Only Secondary Education in Leeds

The Chief Executive of Education Leeds submitted a report regarding the future of Primrose, City of Leeds and Parklands Girls High Schools, and with respect to girls only secondary education in Leeds.

During the discussion on this item it was agreed that the Board discount paragraph 3.6.1 of the report for the purposes of their consideration of this matter.

RESOLVED –

(a) That approval be given to move to formal consultation on a proposal to close Primrose High School in August 2011, and to open a new 11-18

Academy, sponsored by the Co-operative Group, with Leeds College as education partner, on the site in September 2011.

(b) That approval be given to move to formal consultation on a proposal to close City of Leeds High School and for future use of the site for educational purposes.

(c) That approval be given to move to formal consultation on a proposal to close Parklands Girls High School in August 2011, and to open a new co-educational 11-18 Academy, sponsored by the Edutrust Academies Charitable Trust (EACT), on the site in September 2011.

(d) That approval be given for a city wide consultation on the future of girls only secondary education in Leeds.

(e) That a further report be brought to this Board in April 2010 on the outcome of the consultations and progression of the proposals.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting in respect of the proposal referred to in (b) above insofar as the report included reference to a possible future hub development at the site of the City of Leeds High School which will be the subject of a further report)

162 Annual Standards Report - Primary

The Chief Executive of Education Leeds submitted a report providing an overview of primary schools' performance at the end of 2008/9, as demonstrated through statutory national testing and teacher assessment.

A correction in appendix 1 to the report was noted in that reference to the number of schools below the 55% floor target in paragraph 3.8 should read 34 and not 40.

RESOLVED – That the progress made, the implications of the new Ofsted framework and the implications for provision of support, challenge and intervention arising from the government white paper on 21st Century Schools be noted.

163 Annual Standards Report - Secondary

The Chief Executive of Education Leeds submitted a report summarising the progress made in relation to secondary school improvement in Leeds and providing a commentary on the challenges faced with respect to further improvement in the future.

RESOLVED –

(a) That the progress made, the implications of the new Ofsted framework and the implications for provision of support, challenge and intervention arising from the government white paper on 21st Century Schools be noted.

(b) That statistical information be provided to all members of the Board on performance levels in Leeds compared with other similar authorities.

164 Attendance and Exclusions Report 2008/09

The Chief Executive of Education Leeds submitted a report providing a summary of performance with respect to school attendance, persistent absence and permanent and fixed term exclusions in Leeds.

RESOLVED – That the report be noted.

165 Proposal for Statutory Consultation for Changes to Primary Provision in Horsforth in 2011

The Chief Executive of Education Leeds submitted a report on proposed consultation on two linked proposals for primary expansion in Horsforth for September 2011.

RESOLVED –

(a) That approval be given for statutory formal consultation on the linked prescribed alterations to:

i) change the age range of Horsforth Newlaithes Junior School from 7-11 to 5-11, whilst maintaining an admissions limit of 60, with an overall capacity of 420 children; and

ii) change the age range of Horsforth Featherbank Infant School from 5-7 to 5-11, and decrease the admissions number from 60 to 30, with an overall capacity of 210 children.

(b) That the Board notes that the consultation on a proposed expansion of Horsforth West End Primary School, authorised under minute 153 of the last meeting, will coincide with the proposals authorised above.

166 Children's Services Improvement Board

The Assistant Chief Executive (Planning, Policy and Improvement) submitted a report providing an update on the proposal to establish an independently chaired Improvement Board to oversee the implementation of the Council's improvement plan for children's services.

RESOLVED –

(a) That the proposal to establish an independently led Improvement Board be endorsed and that a further report be brought to the February 2010 meeting of this Board with proposed terms of reference for the new board; an outline of the proposed reporting arrangements and an updated Improvement Plan.

(b) That consideration be given to the introduction of arrangements to secure that all political groups are kept informed of progress in Children's Services and afforded the opportunity to support that progress.

ADULT HEALTH AND SOCIAL CARE

167 'Your Hospital Your Say' - Leeds City Council's Response to the Consultation on Foundation Trust Status by Leeds Teaching Hospitals Trust

The Director of Adult Social Services submitted a report on the key strategic issues for the City arising from the public consultation being undertaken by the Leeds Teaching Hospitals Trust on their application to achieve Foundation Trust status and on the proposed formal response by the Council.

RESOLVED - That a formal written response be made to the consultation document 'Your Hospitals Your Say', with specific reference to the points outlined in the conclusion to the submitted report and detailed in section 3 of the report.

CENTRAL AND CORPORATE

168 Leeds City Region Forerunner Agreement

The Assistant Chief Executive (Planning, Policy and Improvement) and the Director of Resources submitted a joint report providing details of the city region Forerunner Agreement which was signed by Government and city region Leaders at the recent City Region Summit on 27 November 2009. The report also outlined the next steps in delivering the programme.

RESOLVED –

(a) That the Forerunner Agreement commitments be noted.

(b) That a further report be brought to the Board detailing the implications of the Agreement and its implementation for Council policy and governance.

(c) That detailed briefing sessions be arranged, one for all political group leaders and members of this Board, and one for each political group.

(d) That further consideration be given to the means of keeping the wider membership of the Council informed of city region developments on an ongoing basis.

DEVELOPMENT AND REGENERATION

169 Legible Leeds - City Centre Wayfinding Scheme

The Director of City Development submitted a report outlining the development of the on-street wayfinding scheme including a new pedestrian focussed 'Walk It' map, concept designs for the proposed new on-street pedestrian wayfinding units and the initial placement plan of where such units should be located.

RESOLVED - That the current position of the Legible Leeds project be noted, that the scheme as outlined in the report be approved and that authority be

given to incur expenditure of £1,200,000 on the proposed works as outlined in the report.

170 Proposed Middleton Enterprise Centre

The Director of City Development submitted a report on proposals for a new Enterprise Centre in Middleton funded by the Local Enterprise Growth Initiative.

RESOLVED – That authority be given to incur expenditure of £1,616,450 on the proposed Middleton Enterprise Centre.

171 Land at Czar Street, Leeds 11

The Chief Officer Libraries, Arts and Heritage submitted a report on proposals to contribute land owned by the Council to support the Old Chapel Rehearsal Studio project.

Following consideration of appendices 1 and 2 to the report designated as exempt under Access to Information Procedure Rule 10.4(3) which were considered in private at the conclusion of the meeting it was

RESOLVED – That land at Czar Street, as identified on the plan attached to the submitted report, be declared surplus to requirements and that the freehold of the land be transferred to Old Chapel Music CIC for the construction of new rehearsal studios in return for the service benefits as detailed in exempt appendix 2 to the report.

172 Chapeltown and Armley Townscape Heritage Initiative Schemes

The Director of Environment and Neighbourhoods submitted a report on the proposed implementation of the Chapeltown and Armley Townscape Heritage Initiative Schemes, in accordance with the schemes' Delivery Programmes as agreed with the Heritage Lottery Fund and the Townscape Heritage Initiative/Town and District Centres Programme Board.

RESOLVED –

(a) That scheme expenditure of £1,136,000 in respect of the Chapeltown and £1,223,000 in respect of the Armley Townscape Heritage Initiative grant schemes be authorised.

(b) That, with reference to minute 258 of the meeting held on 13th May 2009, appropriate officers hold discussions with the Chair with a view to progressing the matter.

NEIGHBOURHOODS AND HOUSING

173 Employability Initiatives

The Director of Environment and Neighbourhoods submitted a report summarising the current claimant rates for out-of-work benefits and providing information on the new employability initiatives to support priority groups back into employment. The report also highlighted the changes required to enable the Council to continue to provide support to priority groups in a changing

funding environment to make best use of resources through partnership working.

RESOLVED – That the work to deliver targeted support to those at risk of becoming and remaining long term unemployed be noted and supported

174 Councillor Kabeer Hussain

The Chair referred to the recent death of Councillor Hussain and the Board stood in silent tribute.

DATE OF PUBLICATION: 8TH JANUARY 2010
LAST DATE FOR CALL IN: 15TH JANUARY 2010 (5.00 PM)

(Scrutiny Support will notify Directors of any items called in by 12.00 noon on 18th January 2010)